THE JOURNAL
OF THE
Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

Vol. XXVI MARCH, 1927 No. 3

ORIGINAL ARTICLES

THYMIC PAROXYSM IN CHILDREN AND ITS PREVENTION*

ERNST A. POHLE, M. D.**
ANN ARBOR, MICH.

Ranking first among the undesirable accidents in surgical practice, we consider thymic paroxysm causing the sudden death of a young individual. There is not much one can do after the typical symptoms appear, but fortunately, we have means of preventing thymic death to some extent. Considering the vital importance of that problem, it may seem justified to discuss in this paper, briefly, the pre-operative management of patients in childhood with this point in view.

The thymus, one of the glands of internal secretion, is of considerable size in the fetal period, usually grows during the first two years of life, remains stationary for the following eight years and begins then to change into a fatty body. We do not know much of its function nor has the product of secretion been discovered. It seems, however, that this organ bears some relationship to the regulation of growth and development. In a number of patients, the thymus appears to be enlarged and when analyzing the underlying pathology we may group that abnormality accord to Warthin, as follows:

1. Relative Enlargement. This includes cases in which the thymus did not reduce as is normally expected and remains comparatively large. Adults with a persistent thymus or better called hyperplasia of the thymus represent the majority of this class.

2. Absolute Enlargement. All cases with a thymus larger than normal in any period of life belong to this group. It may occur as an independent condition or with status lymphaticus, hyperplastic constitution, tonsillar hyperplasia, adenoids, rachitis, congenital struma, exophalmic goitre, myxoedema, cretinism, acromegaly, myasthenia gravis, Addison's disease, epilepsy, congenital syphilis, scorbutus, leukemia, anemia, Hodgkin's disease, anencephaly, and the acute infections. Very seldom a neoplasm is the cause. The type we have mostly to deal with is without doubt that showing a simple lymphoid hyperplasia on microscopic examination.

The enlargement may be discovered accidentally when taking chest films for some other reason, or pressure symptoms draw attention to the thymus. There can be dullness on both sides of the upper part of the sternum. Clinical symptoms are very few and these few may be due to other conditions. The most common symptom is the so-called thymic stridor or difficulty in breathing, and in extreme cases true cyanosis of the face may be observed. In very rare cases death through suffocation caused by pressure of the enlarged gland on the bronchi is possible. Feeding of such a child is also difficult at times. The diagnosis on the roentgenogram is not always easy. There is no typical normal thymus form. The thymus shadow may vary in the same infant; it does considerably so during respiration. Again, enlargement in the anterior-posterior diameter will not show on the usual roent-

* Paper read before the Ann Arbor Session of the American Association of Oral and Plastic Surgeons, Nov. 11, 1926.

** From the Department of Roentgenology, University of Michigan.

genogram, but requires a lateral exposure. In a crying child, the vena cava shows extreme filling. An asymmetrical position (rotation) of the patient when taking the film is also sometimes misleading. As to the frequency of enlarged thymus in young children there are no reliable statistics available. Some authors give as an average 50%; it is undoubtedly higher in countries with endemic goitre.

Aside from the extreme cases where disturbance of breathing and feeding necessitates therapy, the clinical importance of the enlarged thymus lies in the fact that such patients present, as sad experience has taught us, an increased surgical risk. The question arises, what can be done for the prevention of undesirable accidents before, during, or after an operation, and what are the indications to be followed. I would like to say right here that surgical removal or reduction of the thymus has been given up entirely, and since we know that thymus tissue is one of the tissues most sensitive to radiation, radiation therapy in the form of roentgen rays or radium is the method of choice. The writer prefers roentgen rays although there are roentgenologists who use radium. They argue that radium application does not require fixation of the patient and does not introduce the possibility of a shock. We have, however, never seen a bad result due to the excitement that is always connected with the administration of roentgen ray treatment to babies with an enlarged thymus. The usual technique as given in literature is 100 to 130 KV, 3.0 to 4.0 aluminum, giving a dose of 20 to 30% of the erythema dose. This may be repeated if necessary in one month. We use a filter of .25 mm. copper plus 1 mm. aluminum giving only 10% of the erythema dose in a single exposure. We can safely repeat this dose six times if indicated in short intervals without even reaching the skin tolerance. One must realize that the cells in a young growing organism are more susceptible to radiation than those in an adult. We have, therefore, to try to bring about the desired effect with the minimum amount of roentgen energy. A result may be expected in favorable cases after 24 to 48 hours. As to the possible danger of impaired function, one must remember that in animal experiments, a complete regeneration of the glandular tissue following radiation has been observed. Cases of toxemia following radiation of the thymus with fatal outcome are also on record; the occurence seems to be especially rare and quite unexplained.

It is our impression that irradiation of an enlarged thymus in cases of thymicolymphatic constitution cannot have a curative effect; it is hard to believe that a constitution may be changed by roentgen raoy exposure. We advise, however, to terat such a case before an attempted operation. If an accident occurs, there is no reproach that everything has not been done to prevent it.

Regarding patients with goitre accompanied by an enlarged thymus, it is interesting to know that Kocher, the famous Swiss goitre surgeon has advocated a prophylactic X-ray treatment to the thymus before thyroidectomy. Some investigators treat as a routine the thymus whenever subjecting a case of goitre to radiation therapy.

Our indications for treatment of simple hyperplasia of the thymus have been worked out on the following basis. In all suspected cases stereoscopic films of the chest are made before the first therapeutic exposure; if the films show enlargement, treatment is given and the patient re-examined by roentgen rays after one month unless alarming clinical symptoms require treatment before that time; if the films are negative, and if there are no clinical symptoms, the patient is discharged; in a case with clinical symptoms but negative X-ray findings, we also advise roentgenotherapy and repeat treatments in monthly intervals until the symptoms have cleared up. In Table I, we report the thymus

TABLE I.

Total	Cleft Palate, Hare Lip or Both	Symptoms Only	Symptoms and X-Ray	X-Ray Only	Preoperative Prophylaxis
88	17	12	24	50	2

cases which we treated in our department over a period of one year. They are classified according to the indication for treatment, i. e. treated on the basis of symptoms only, of positive X-ray findings, of positive X-ray findings plus clinical symptoms, and pre-operative exposure only for prophylaxis. Another column shows the number of enlarged thymus patients who had cleft palate or hare-lip or both. In all cases which responded to the treatment, an average of two treatments was required. A few typical cases will be illustrated here.

Case X 5589—This is a definitely enlarged thymus which responded promptly to one treatment. (Fig. 1 and 2).

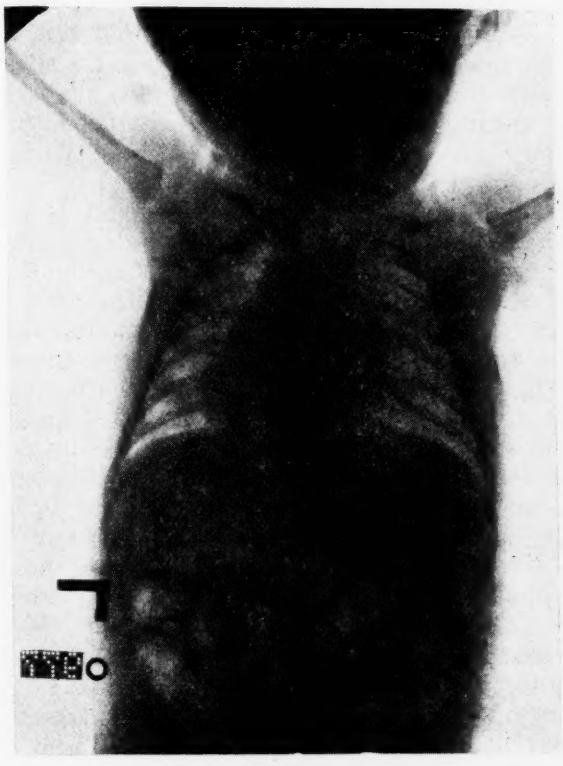


Figure 1

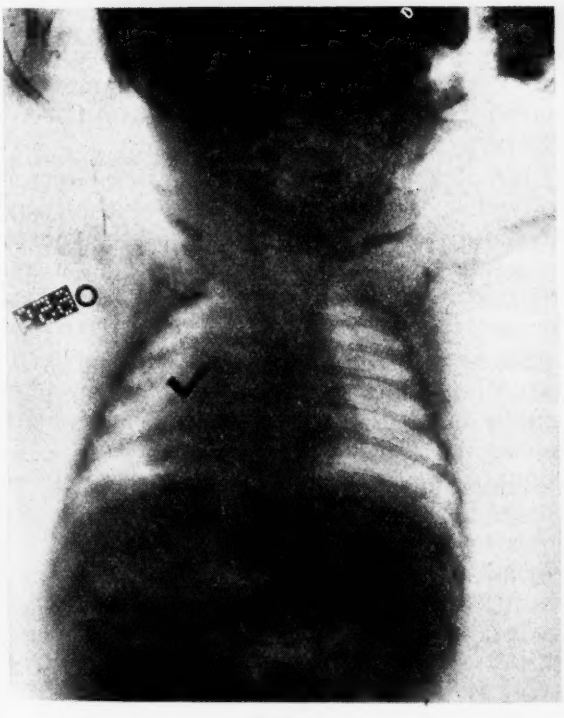


Figure 2

Case X 5208—Three treatments were required in this patient to reduce the thymus to normal size but it finally responded and cleared up. (Fig. 3 and 4)*.

* Fig. 3-10 will not be reproduced, as they show practically the same changes.

Case X 5466—The thymus in this patient did not respond at all to roentgen ray exposure although six treatments over a period of five months were given. (Fig. 5 and 6).

Cases X 5780 and X 5744—The next two roentgenograms are interesting because they are taken of twins; one (Fig. 7 and 8) shows prompt response, the other (Fig. 9 and 10) is still persistent.

We lost one case through thymic paroxysm although several treatments had been given. The history follows:

Case X 5694—Girl one week old, admitted with a diagnosis of club feet, unilateral hare-lip and bilateral cleft palate, on July 26, 1926. Stereoscopic films of the chest taken on July 7, before admission showed enlarged thymus. Treatment was given on July 29, 1926. Chest films taken on August 13, did not show any change in the size of the thymus. Another treatment was, therefore, administered the same day. Check up films made on August 26 and 28, still showed evidence of thymic enlargement. Another X-ray treatment was given on August 30, 1926. On September 14, X-ray examination revealed the thymus decreased in size. The following day the patient was given 100 c.c. Ringers solution at 8:30 a. m.; taken to O.R. at 10:30 a. m.; returned and condition appeared good except for slightly labored breathing. Oxygen advised. At 1:30 the nurse reported sudden rise in temperature and very shallow breathing. Caffeine and adrenalin were given without marked effect. Artificial respiration and forced oxygen were also useless and at 2 o'clock respiration ceased. The patient felt extremely hot and color was ashen when seen at 1:30. The impression was that of a thymic paroxysm postoperative. Autospy confirmed this clinical diagnosis.

From our observations, we conclude that it is impossible to tell before-hand whether an enlarged thymus will yield to treatment or not, and whether this treated thymus will later continue to be the cause of surgical shock. There is also no way to exclude the possibility of surgical shock even if the roentgenogram does not show enlargement of the upper mediastinum. Although we do not want to go on record and state that for this reason it is necessary to give all patients in the early stage of life a prophylactic treatment, we cannot criticize any surgeon who insists on such a procedure. He may rightfully reason that prevention is better and easier than cure or repair. There is no doubt, however, that roentgen examination of the chest of all young individuals before undergoing an operation seems to be advisable.

SUMMARY

1. Various types of thymic enlargement and their importance in surgical cases are discussed.

2. The technique of preoperative roentgenotherapy as used in the Department of Roentgenology, University Hospital, Ann Arbor, Mich., is given.

3. Preoperative roentgen ray treatment of the thymus should be administered, at least, in all positive and doubtful cases of thymic enlargement, the diagnosis being based on clinical or roentgen ray findings.

4. Routine preoperative roentgen examination of the chest of young individuals is recommended.

TREATMENT AND PROPHYLAXIS OF SCARLET FEVER

H. E. BAGLEY, M. D.
DETROIT, MICH.

I do not propose to deal with the old-established methods of treating the disease, but, will attempt to outline results obtained at the Herman Kiefer Hospital, Detroit, in the treatment and prophylaxis of scarlet fever with some of the comparitively new toxin and antitoxin serums, commercial products now on the market. I shall also touch briefly on work done with human convalescent serum and also with a bacteriophage the work of Dr. R. W. Preyer of the City of Detroit Laboratory.

I have dealt with my subject under the following headings:

1. What the serums are and how obtained.
2. Uses of the serums.
3. Experiments at Herman Kiefer Hospital with these serums and their results.

Of the commercial products there is a toxin and antitoxin.

Scarlet fever toxin is obtained from filtrates of fresh live virulent cultures taken from the throats of patients suffering from scarlet fever in the severe form. This is the toxin the same toxin that is used for the Dick Test.

The antitoxin is obtained by treating horses with gradually increasing doses of the toxin until an immunity is established by the horse. The horse's serum then contains antitoxic and antibacterial properties. Some pharmaceutical companies claim that their products contain both antitoxic and antibacterial properties whereas other companies only mention the antitoxic properties.

The serums are concentrated, purified and tested as to sterility and antitoxic potency before being put on the market.

At the Herman Kiefer Hospital last year experiments were made with serums put out by the following pharmaceutical companies: Park Davis, Dick serum made by Squibbs, Dick serum made at their own laboratory, Lilly and a very few cases with Lederle serum.

Apart from the above serums human convalescent serum was also used. However, this method of treatment is, properly speaking, not new for it has been used with very good results at the Herman Kiefer Hospital for several years.

This human convalescent serum is obtained as follows. Adult male scarlet fever patients are given a Wassermann test. If this be negative, and if the patient can be persuaded to give it, about three or four hundred c.c. of blood are taken. This is done a few days before the patient is dismissed. The serum from this blood, which is roughly about half the volume of blood taken, is then tested for sterility and a preservative added in the form of ¼ of 1% phenol. This serum may be kept in an ice chest for several months without apparent loss of potency.

The usual dosage of this human convalescent serum is 30 c.c. given intramuscularly. To my mind this serum offers the very best means of combatting the disease, but, it is of course hard to obtain and is really only an institutional measure.

BACTERIOPHAGE

Some very interesting and profitable work was done with a bacteriophage prepared by Dr. R. W. Preyer of the City of Detroit Laboratory.

Dr. Preyer contends that other bacteria as well as the strepticoccus are the cause of the disease. Also, that the strepticocci may under varying condition mutate and become staphlycoccic or colon in form thus accounting for many of the complications.

He proposes to combat the disease by injecting intramuscularly bacteriophage which literally eats up and destroys the bacteria.

There is no doubt about the ability of this substance to destroy bacteria in a test tube, and, from results obtained in a number of cases of scarlet fever in which it was tried it would appear that it had exercised the same power in the human body.

USES OF THE COMMERCIAL SERUMS

The toxin is used in carrying out the Dick Test for determining the susceptibility to scarlet fever. Either one or two skin test doses of the toxin are used for this test. This must be given intradermally, for, if injected too deeply, a positive result will not be obtained, even in those

susceptible to the disease. We found that the test should be read after 24 hours, not 48 hours as with the Schick Test.

The toxin is also used for the active immunization of susceptibles. For this active immunization gradually increasing doses of the toxin are employed. The amount of toxin given and the number of injections given vary with the products of the different pharmaceutical companies. One company advises four subcutaneous injections of one c.c. each at intervals of from five to seven days. The dose is the same for children as for adults.

Dose One	250 Skin Test Doses
Dose Two	500 Skin Test Doses
Dose Three	1000 Skin Test Doses
Dose Four	2000 Skin Test Doses

This active immunization should not be attempted if the person has already been exposed to the disease, for it does not afford protection until the last dose of the series is given, and this of course is about four weeks after the first injection. In dealing with such a case the proper procedure would be passive immunization, which I shall discuss later.

This active immunization was not carried out at the hospital.

USES OF THE ANTITOXIN

The antitoxin may be used for two purposes—passive immunization and treatment.

A small amount of the antitoxin (about 2½ c.c.) given intramuscularly at time of exposure to the disease confers a passive immunization which appears to last about two weeks. Wonderful results were obtained at the hospital with this passive immunization. For, during the course of the year, a number of patients with the wrong diagnosis were inadvertently admitted to the scralet fever ward, where they remained over night. On discovery of the mistake the following morning they would be removed from the ward and given 2½ c.c. of scarlet fever antitoxin. Not one of these patients came down with the disease. Early in the year these patients were kept in a private room in a different part of the hospital for one week after the exposure before dismissal. Later, we became so sure of the immunity conferred by the antitoxin that the patients were given the serum and sent home at once.

On other occasions scarlet fever broke out in our diptheria and measles wards. In these cases the scarlet fever patient would be immediately removed and all the other patients would be given the Dick Test. Those who were positive would be given 2½ c.c. of antitoxin and again almost perfect results were obtained.

From the above results it will be seen that scarlet fever antitoxin affords a valuable means of securing passive immunization. It is of great value to the practioner in guarding against the spread of scarlet fever in the home if the patient can be completely removed from contact with other members of the household, and the other members who have not previously had the disease, given 2½ c.c. of the antitoxin at once. In this case I think that the serum should be administered at once without waiting to give the Dick Test. It must be remembered that the immunity conferred by this antitoxin will probably not last the whole 28 days or more of the disease. That is why segregation of patient from susceptibles, especially of children, is advisable.

TREATMENT OF THE DISEASE WITH THE ANTITOXIN

The greatest stress is of course laid by the pharmaceutical companies on the use of the antitoxin in the treatment of the disease itself. The standard dose for treatment is 10 c.c. given intramuscularly. This should be given as early as possible. If the case is not doing well after 24 hours it should be repeated. This dosage is the same for children as for adults.

The results obtained by us would in some respects tend to show that the companies had over-estimated the value of the serum in this direction, yet, these same results clearly indicate, that, if a patient were quite sick the antitoxin should be given. It will be almost sure to reduce fever and toxic condition to quite a marked degree within 12 to 24 hours. There is a drawback due to the fact that after perhaps a week or so he may suffer somewhat from serum sickness. This is, of course, due to the fact that the serum is obtained from the horse. However, at the time when this reaction usually occurs the patient should be well enough to stand it easily. Then again he may escape the complication altogether. At the Herman Kiefer Hospital serums were only given to the more severe cases, because the milder ones would probably be all better in a few days anyway, and then again there was not enough material for it to be given to every case. All patients, who on admission had a temperature of about 102.6 or over and who gave other evidence of being quite ill

were given serum of some sort. It must be remembered that patients are practically always sick for about two days before coming to hospital. A few would be cases who had been sick for several days and probably only came to hospital because they were going bad.

An effort was made to find out which commercial serum was the most efficient and a comparison was made between the serums which I have already mentioned. But, as 128 cases were treated with Park Davis' Serum, and only 19 cases with Squibb's Serum, 14 cases with Dick's Serum, 11 cases with Lilly and 3 or 4 cases with Lederle's Serum, it will be seen that the number of cases treated with the various serums was so unequal, that, although results were charted separately, it was hardly a fair comparison. Therefore, it would not be just to give these separate results here. Instead of this I will give results as recorded in the combined charts of the various serums.

Average temperature of cases which received some variety of commercial serum was 102.6 at time of administration. After five days the average temperature was 99.4. The greatest drop was usually within the first 24 hours after giving the serum. Temperature is of course only one factor to consider. The truth of the matter is that very good results were obtained in combatting toxemia. That is to say, if a patient were admitted with a very bright heavy rash, severe sore throat, high fever, rapid pulse and perhaps showing signs of delirium, there would practically always be marked abatement of these symptoms within a few hours after the giving of 10 c.c. of commercial serum.

On the other hand rather poor results were obtained in combatting complications of the disease. Later, in the course of the disease if a patient, who may or may not have had the serum, developed complications serum appeared to have no effect on them. That is to say running ears, septic sore throat, threatening mastoiditis, nephritis, adenitis, etc. are not affected by the giving of serum. However, it is quite possible, even probable, that if the serum be given early many of the usual complications are warded off because of the general improvement in the condition of the patient.

One hundred and seventy-two cases received commercial serum. These cases suffered the following complications:

Cervical Adenitis	19%
Arthritis	19%
Otitis Media	11%
Rhinitis	12%
Albuminuria	10%
Real Nephritis	2%
Endocarditis	5%
Mastoiditis	6%

There were seven deaths.

It must be remembered that all these cases were severly ill on admission.

The serum nearly always caused some urticaria. Sometimes this was quite bothersome. Some cases suffered from joint pains for a few days. None of these symptoms were alarming except in the case of one little boy who got a severe reaction almost at once. This was easily controlled by the giving of adrenalin.

CONCLUSIONS

Commercial antitoxin is excellent for temporary immunity.

Human convalescent serum is perhaps the best treatment for scarlet fever, but, is hard to obtain and is really only a hospital measure.

Commercial antitoxins are good to combat toxemia. They have no apparent effect on complications that have already become established.

The experimental work, which I have briefly dealt with, was done under the direct supervision of Dr. Guy L. Kiefer, chief of hospital staff.

He was assisted by the following men who were resident physicians at the time: Dr. Gordon Knapp, Dr. A. B. Winograd, Dr. D. E. Cohn, Dr. E. Martner and by Dr. B. Bernbaum, who is one of the visiting physicians of the hospital. I was chief resident physician.

All the commercial serum was furnished free of charge by the different pharmaceutical companies. That from Squibbs and from the Dick Laboratories was obtained through the courtesy of Dr. C. C. Young, director of the Michigan State Laboratories.

VARIABLE FACTORS IN LACTIC ACID MILK FEEDING

DAVID J. LEVY, M. D.
DETROIT, MICH.

The popularization of concentrated foods in the feedings of infants represents a significant trend in recent pediatrics practise. True, for many years past, the use of buttermilk re-enforced by the

addition of flour and sugar has been common practice. There followed the introduction of the high caloried malt soups, albumin milk, butter flour mixtures, the various acidified milks, particularly lactic acid milk, and others. The use of concentrated food approaches natures own method of feeding. The milk the baby takes from its mother's breast is undiluted and unmodified. The methods of diluting and adding to cow's milk to enable it to approximate the effects of mother's milk have parallelled our changing views in regard to the etiology, physiology and pathology of the processes of nutrition and metabolism. In a recent visit to several of the more important European Clinics, milk dilutions were found largely out of vogue except in the form of butter flour mixtures. To meet certain indications, Finkelstein was employing a nearly doubly concentrated albumin milk containing 20% sugar addition. Properly balanced milk dilutions have, however, undergone a prolonged and thorough going clinical test and should remain the method of choice in the routine feeding of healthy infants. However, concentrated foods have an exceeding value when prescribed to meet certain indications and it behooves us to give consideration to certain factors involved in the most commonly used of these.

The most recent step in infant feeding has been the introduction and wide spread use of lactic acid milk. In this we find a food not only concentrated in form, but of a buffer content, approximating that of mother's milk, with the consequent offsetting of the inhibiting action of the cow's milk and the facilitating of the whole subsequent digestive and nutritional cycle. We are thoroughly indebted to Marriott for his emphasis on this important principle.

There has been an over enthusiastic and unlimited adoption of lactic acid milk in routine feeding in some quarters, an unnecessary aloofness in others. In fact, our whole experience is too recent to enable one to define exactly the limitations, the indications and contraindications of its use. Faber has recently set forth fairly accurately the present status of the question. However, in determing our attitudes, it must be remembered that lactic acid feeding does not represent a standardized method, that there are variable factors in its use which determine the clinical results obtained, and it is purpose of this paper briefly to discuss several of these more important variables—namely, the fat, the sugar and the acid itself.

Infants in general tolerate whole milk when it is properly acidified. However, certain conditions arise in which a diminution of fat is indicated—notably in the feeding of new born infants and in vomiting conditions and in celiac disease. Administration of the fat sometimes influences favorably a constipated condition, although a hard, dry stool is, to my mind, a contraindication to the continued use of lactic acid milk. Lactic acid milk meets one of its most valuable indications in the feeding of the new born either as complemental or supplemental feeding or as complete feeding when mother's milk is not available whatsoever. For the first few days of the infant's life, fat free milk is indicated—within a few days, one-half skimmed milk is well tolerated, and in the average healthy baby, whole milk may be employed within the very early weeks.

A word of warning may not be out of place here in regard to skimmed milk feeding, whether in the acidified or non-acidified state. Skimmed milk suffice only for temporary feeding. Its long continued use deprives the infant of an indispensable essential to its diet. A long deprivation of fat results in lessened deposit of body fat, lessened tone and turgor of the body tissues, and lessened immunity and resistance possibly due to the diminution of the essential fat soluble vitamin substance. Besides, an extraordinary volume of food is required merely to cover the child's caloric need. An added gravity is added to the fault when the skimmed milk is prescribed diluted. Clinical conditions apparently calling for this type of management can be met in more rational and logical ways.

It must be remembered always when full lactic acid milk mixtures are employed that carbohydrate must be added to permit the proper metabolism of the fat present. Fat is burned in the body in a fuel of carbohydrate—and always an adequate amount of fuel must be prescribed to permit the burning of the fat in the mixture. The tendency in general is to prescribe inadequate amounts of sugar. Remember that the sugar content of cow's milk is approximately 4.75%, and that of mother's milk is 7%. Enough sugar must be added to the whole milk mixture to bring the total sugar content to approximately this latter figure. Sugar in general may be administered with a greater sense of security than feeding practice in recent years

has apparently found warranted. In the presence of high protein and fat as in the concentrated formulas under discussion, the laxative tendency of sugar is not very manifest. However, the use of excessive quantities also is not indicated. In my experience, four tablespoonfuls per quart of corn syrup is the optimum dosage. Smaller quantities are indicated at the begining of feeding of the new born and in undue looseness of the bowels. The opposite extreme is also to be avoided. The seven tablespoonfuls used by some is excessive dosage. If this quantity seems necessary because of constipation, the remedy lies in milk dilutions and not in over-concentrated feeding.

The greatest lack of uniformity of method, however, is shown in the quantity of lactic acid prescribed by various individuals. Marriott has recommended the employment of 8 gm. per liter of milk. This quantity no doubt accomplishes a complete debuffering of the milk—a situation which most observers apparently agree is not necessary to bring about. Faber emphasizes the danger inherent in administering completely debuffered milk. The experiments of Klotz are fairly conclusive that beyond 4 gm. per day—and even at this figure—a negative calcium balance may be brought about in the infant organism.

A recent informal survey of a considerable group of pediatricians proved interesting in regard to the quantity of lactic acid prescribed by each. The quantities varied from 30 drops per quart to 240. Higher amounts were employed by very few, and the largest number averaged about 90 per quart or 3 drops per ounce. Some individuals varied the amount employed—reducing as the clinical condition of the patient improved. Others did not prescribe by drops but employed a visual method giving instructions to add lactic acid until a curd producing a definite consistency of the milk was attained. Practically all prescribed a dosage measured in drops rather than in minims or cubic centimeters. It must always be remembered in discussing the dosage of lactic acid that drops and minims do not coincide—that one dram of lactic acid contains ca. 120 drops. Also, the drops themselves vary in size, depending upon the opening of the pipette employed—a jagged or flanged pipette delivering a larger drop than the straight cut, pointed eye dropper commonly employed. Lactic acid also may vary in its pharmacopeal strength between 85% and 90%. Furthermore, it takes up moisture readily and the acid may become, if improperly stoppered, more dilute and weaker. However, when milk is only partially debuffered, the size of the drops and the variation in number within small limits is negligible as to effect.

In my own opinion, and apparently in the opinion of most of the local confreres, partially debuffered milk meets routine requirements—and higher acidities are to be employed only in the more severe conditions and for short periods only—with gradual reduction of the strength employed. Probably 4 gm. or roughly 120 drops per quart represent the maximum dosage for routine cases, and the optimum is possibly somewhat less than this figure. When used in limited dosage in properly balanced mixtures, lactic acid may be given over considerable periods of time. When the baby who has hitherto been taking the sour milk well and thriving on it ceases to gain or evinces a distaste for the milk or developes hard, dry stools, the continuance of the use of lactic acid milk is contraindicated.

While lactic acid milk on account of its sterility and its value under certain conditions of deranged nutrition would seem of increased value and practicability during the summer months, the onset of the hot weather this year found many mothers unable to prepare satisfactorily the milk which there had previously been experienced no difficulty. The apparent reason was that owing to increased temperature a partial lactic acid fermentation had occurred in the milk previous to, during or subsequent to its delivery, so that the milk would not carry, so to speak, the customary quantity of lactic acid. In an attempt to answer this question the aid of the Walker Gordon Laboratory in Detroit was asked, and thanks to its courtesy and the interested efforts of its bacteriologist, Mr. Farr, a large number of specimens of milk—certified, pasteurized, ordinary, boiled, milk which had been properly kept, and milk which had been allowed to stand at room temperature for varying intervals, were tested as to hydrogen ion concentration; as to the amount of lactic acid necessary to bring it to a ph. of 3.7; as to its titrable acidity in terms of lactic acid; and as to the quantitative bacteriological content. This investigation is still under way and it is still too soon to report the findings. However, the results obtained to date are largely negative and tend to show that within limitations, the ageing of the

milk and the number of bacteria present per se have no important bearing on its hydrogen ion concentration, the determining factor being more likely the type of bacteria, i. e., acid producing organisms—present. There is a fairly constant initial hydrogen ion concentration in milk kept under average conditions and the range of lactic acid necessary to bring 10 c.c. of the various milks to a ph. of 3.7 varied within narrow limits. In a further interesting series with control of mother's milk, the amount of lactic acid necessary to bring the cow's milk to a ph. of 3.7 varied between 2 to 3 times as much as was necessary to bring mother's milk to the same point instead of three times as stated by Marriott and Davidson. If these latter figures are confirmed, they will furnish added authority for the use of the smaller quantities of lactic acid.

If one may draw any conclusions from these observations, one may infer that the acidity of milk of various origins and kept under approximately normal conditions is fairly constant and that the quantity of lactic acid necessary to bring it to a definite hydrogen ion concentration varies only slightly in proportion.

It is not within the scope of this paper to discuss the acidification of milk by other acids—such as hydrochloric, citric and acetic—or the employment of cultured milk, but merely to emphasize the variable factors that must enter into consideration to permit a fair estimate of the indication, contraindications and limitations of the use of milk to which lactic acid as such is added.

THE TUBERCULOSIS PREVENTORIUM*

CLARENCE A. RYAN, M.D.C.M.
NORTHVILLE, MICH.

The methods in use for the prevention of tuberculosis have been widely discussed, so that the subject is far from new. However, there is sufficient interest being taken in such work to warrant frequent publications upon the subject.

Preventorium work has been carried out at Spring Hills Sanatorium for the past five years. So far, this has been on a comparatively small scale, considering the population which is cared for by the Sanatorium. The method in use here has been to maintain a "summer camp" for four months of the year; that is, from June to the first of October. Each year groups of children are selected partly from homes where open cases of tuberculosis were found, partly from amongst the children of the open-air schools, and partly from homes visited by the nurses of the Detroit Department of Health.

In 1920, this work was first undertaken here, and for that summer tents were used to house the children. Since the camp is continued until the first of October, tents were not found satisfactory during the latter part of the time. Partly for this reason and partly in order to establish a permanent place in which to carry out the work, the present group of buildings was constructed in 1923. These are stucco-finished buildings, containing in the center a dining room and kitchen, with living quarters for the nurses on the second floor, and on either side a ward building containing 50 beds in each ward, thus providing accommodations for a total of one-hundred children. A store room, and a recreation, or play room, is also provided.

In all previous years the groups were made up of half boys and half girls. This year, with the intention of making "heliotherapy," part of the camp routine, the groups were separated—the first group composed altogether of girls, the second group of boys. This gave the girls the two better months, June and July, so that the benefit from the heliotherapy, in so far as result could be estimated from the degree of tanning, was better in the girls.

This year also, the groups were composed of children taken almost wholly from families where there were known cases of tuberculosis, five parents being patients in the main buildings, three of the children having brother or sister in the children's unit.

On admission all children, as formerly, had a complete physical examination, X-ray, and dental, and their weights charted. The following gives some idea of the findings:

	Girls	Boys
X-Ray (increased hilum or parenchymal shadows)	35%	6%
Hypertrichosis	31%	18%
D'Espines	25%	23%
Cervical	16%	61%
Tonsils	36%	31%
Scapulae	not done	Winged 21% Concave 12% Winged and Concave 28%
Other physical signs	9%	4%

In addition, three of the girls and two of the boys were found to have signs sug-

* Physician, Children's Unit, Wm. H. Maybury Sanatorium, (City of Detroit Department of Health).

gestive of active tuberculosis and were transferred to the children's division of the Sanatorium for treatment.

During the stay here interdermal tuberculin tests were made on all of the children, starting with 1/10 c.c. of a one in 100,000 dilution of O. T. and increasing by 10 times the dose every week up to a dilution of one in 10. The very dilute dosage gave so very few reactions in the girls that it was decided to drop that dilution in the boys and start with the one in 10,000. In the girls, the time did not allow carrying the tests up to the full strength of one in 10 and the tests were stopped at one in 100 dilution. The boys were given the higher strength. Of the girls 36 per cent gave a positive reaction, and 12 per cent a questionable result; that is, less than a 5 m.m. erythema at the point of injection. In no case was an elevation in temperature noted which could be interpreted as resulting from the Tuberculin. The boys gave a positive reaction in 55 per cent and questionable in 15 per cent. In addition those boys which did not react to interdermal tuberculin were given the Von Pirquet cutaneous test. Not one reacted to this test. In the different age groups (taken by years from 5 to 14) the 12 year olds seem to be the most sensitive, all of the girls in the age group giving either a positive (84 per cent) or a questionable (16 per cent) reaction, and 73 per cent of the boys (47 per cent positive and 26 per cent questionable).

Malnutrition was estimated upon the percentage of normal weight. All 8 per cent or more under normal being checked as being in this group. Forty-nine per cent of the girls and 69 per cent of the boys on admission fell into this classification. On discharge 8 per cent of the girls and 9 per cent of the boys were still in this class, although in every case great gains were made. The average gain in this class amongst the boys being 7.2 pounds and girls 5.8 pounds. Failure to gain can perhaps be attributed to some one or more of the following physical and other signs: X-ray (7), tonsils (6), cervical glands (6), positive D'Espines (4), asthma (1). In one case the child was watched from the admission to the camp to its close before being transferred to the Sanatorium. This child is also included in the malnutrition group.

On admission to the camp 16 of the girls showed some physical signs on chest examination, which were not considered due to tuberculosis. All of these cleared up before discharge. Of the boys, only four showed abnormal signs, which also cleared.

There has been some discussion whether the shape and position of the scapulae have any bearing on the physical condition. Of the boys (and the boys only were examined in this case) all that could be deducted was that concave or winged scapulae were frequently associated with malnutrition but were not to be considered of any definite diagnostic value. Hypertrychosis also is to be considered of the same practical value. The percentage for both of the above were given earlier.

On the whole number of children admitted this year (205) the average gain has been 5.71 pounds. This average gain has been exceeded only once, (1923; 5.8 pounds). Heliotheraphy was made such extensive use of this year that it was the expectation that the average gain would be much less than previously, whereas, on the contrary, the gain is well up in the average for the five years of the camp.

This ends the fifth year of preventorium camp work at this Sanatorium, in compiling our figures, a stay of less than three weeks has not been considered as sufficient time to give any result. In the case of the boys who came to the camp in the latter months, several vacancies occurred during the term of camp owing to removal of the boys for school and such reasons. These vacancies were, in most part, filled from the Children's division of the Sanatorium, and in such cases the child going to the camp had had several months treatment in the Sanitorium and was considered in such physical condition as to be able to return home. Such being the case it is not to be expected that these boys would show any very great gains in the camp, and for that reason the average gains are perhaps a little lower than they might otherwise have been. During this year, no child lost weight. One child gained 24 percent in weight.

As a summary of the past five years:

Year	No. of Children	Average Gain
1922	100	4.2 lbs.
1923	208	5.8 lbs.
1924	204	5.7 lbs.
1925	205	4.8 lbs.
1926	205	5.71 lbs.
5-year record	922	5.24 lbs.

Each year two or three children are found in the groups who are in need of Sanatorium care. This year, as has been said, five were transfered from camp to unit. During the time that the preventorium has been in operation, only 10 children

have been found amongst the total of 922, to have developed active pulmonary tuberculosis, that is about 1 per cent.

As each group leaves the preventorium, recommendations are made to the Board of Health concerning their physical condition and their follow-up treatment. As an indication of this work may be quoted the recommendations of this year:

Twenty-one boys and eight girls were recommended for tonsilectomy.

Sixteen boys and 19 girls noted as having enlarged tonsils but not requiring immediate removal.

Nine girls and three boys recommended for future examination to see whether the gains made at the camp were held.

Two girls were recommended to have ears treated.

Two girls were recommended for medical treatment for asthmatic conditions.

Seven girls and 10 boys were considered to have a D'Espine's sign suggestive of a possible infection and were recommended for frequent re-examinations.

Thirty-five boys and 13 girls had sufficient reaction to interdermal tuberculin to warrant future examination.

The fact that so great a number of recommendations were necessary, and so many showed indications that they may later develop active disease, leads to the conclusion that preventorium work must be carried out more fully in the future and if possible, a permanent preventorium be established to give longer observation to such cases, and also to those cases which are constantly presenting themselves to the Children's Unit, in whom, while no definite disease can be demonstrated, still have sufficient indefinite indications and suggestive symptoms to warrant observation, but for whom there are not sufficient Sanatorium beds to provide institutional care.

PROSTATIC NODES—THEIR CLINICAL SIGNIFICANCE

NOAH E. ARONSTAM, M. D.
DETROIT, MICH.

Upon rectal examination the normal prostate imparts a uniformly smooth and even surface in both lobes and isthmus. It encroaches upon the rectal lumen, so that a perceptible projection is readily distinguished, but not enough to suggest an actual ridge or crest. Exceptions to this gross anatomical rule do occur, but in the majority of cases the above delineation holds true.

Diseases, such as gonorrhea, tuberculosis and malignancy may give rise to alterations in the anatomical contour of the gland. Without underestimating the gravity and importance of the latter two, I shall dwell mainly upon the former as an etiologic factor of moment in the causation of nodular formations in the prostate. It may be stated with certainty that 75 per cent of all cases of prostatic nodes are the result of gonococcic invasion, and form no inconsiderable contingent to the type of so-called "chronic gonorrhea." Unhappily our medical momenclature for centuries has been responsible for the ambiguity that still clings to the various descriptive terms, such as chronic gonorrhea, chronic urethritis, etc. A chronic gonorrhea or urethritis is not always a chronic involvement of the urethral canal, particularly so when induced by gonococcic prostatic infection or spermatocystitis of the same origin; it should be termed gonococcic prostatis or prostatitis gonorrhoica and gonorrheal spermatocystitis respectively. When the gonoccocci gain entrance into the ducts and crypts of the prostate through the process of extension, proliferation of the parenchymatous tissue takes place with a concomitant plastic exudate into the stroma of the gland, so that in the course of time nodes may develop in the substance of the prostate, particularly so in its lobes. Very rarely, if ever, do we find the isthmus implicated. When such a prostate is examined—and for a proper and thorough examination, we must use very thin finger cots if possible, so as not to blunt the sense of touch to any inconsiderable degree—instead of detecting a smooth and even surface, the finger readily recognizes elevations in the substance of the gland, prominences here and there, separated by normal prostatic tissue. If pressure is brought to bear upon these nodes—as they may be termed—one of two kinds can be readily discerned: soft, elastic and yielding prominences, the so-called *soft nodes;* or indurated, resisting and plastic ones—*hard nodes.*

The former are accompanied by a more or less copious discharge of prostatic fluid at the meatus, the latter yield very little or no secretion. The prostatic secretion thus obtained harbors numerous cocci, among which the gonococci are easily detected. It is often very difficult to obtain secretion for microscopic examination from the hard nodes.

Urethroscopic examination, both anterior and posterior is negative, and the only apparent evidence of gonococci infection, therefore, is in the prostate. The urine of the patient suffering from soft prostatic nodes, upon a three or five glass test, may show flocculi and filaments in the second and third tube (with preliminary irrigation), and in the fourth and fifth tube upon prostatic massage. In those suffering from indurated nodes, the urine presents a negative character, so that little dependence is to be placed in such a case upon a three-or five glass test. Ascitic-agar cultures frequently yield colonies from the prostatic fluid expressed from the soft nodes.

The clinical significance of these nodes is obvious. While the patient may be entirely free from a urethral gonorrhea and the urethroscope fail to elicit any positive evidence of infection, the prostate is the organ that bears the brunt of the infection. This may continue indefinitely for years, with frequent recrudescences in the form of an acute specific urethritis, a potent source of infection to others and a menace to the individual's health. That there is a constant absorption of gonotoxin, has been proved by many observers, the effects of which manifest themselves in the form of different myalgias and arthralgias with no appreciable alterations in the muscles and joints affected. Other vague symptoms are complained of by the patient, which I believe have their origin in the prostatic lesions. Hence nodular involvement of this organ should always be considered a sequela of moment, and not lightly dealt with. Our conception of gonococcic infection in general may change radically within a decade or two. It is to be no longer regarded as a local infection only, but as a systemic disease of far-reaching importance.

It has long been determined that the seminal secretion without the admixture of the prostatic fluid loses one of its essential elements in the process of impregnation. The spermatozoa without this auxiliary function of the secretion of the prostate are inactive. A pathological secretion of the prostate, therefore, is unable to activate the seminal fluid and sterility may thus be the outcome. Another function of the prostatic secretion that has not been universally recognized is its influence upon virility. While in a great measure the prostatic fluid is eliminated by ejaculation and unconsciously escapes with the urinary stream, and occasionally appears at the meatus, some of it is also absorbed and has a powerful effect upon the sexual potency, not unlike that of the testicular hormone which has long been known to materially influence it. An absence or pathologic modification of the prostatic secretion, either qualitatively or quantitatively, induced by gross morbid conditions of the gland will in time give rise to partial or complete impotence, aside from the biodynamic role the prostatic fluid plays in activating the seminal secretion. Hence the clinical significance of prostatic nodes the result of gonorrheal infection, will become apparent to the practitioner at a glance, if he bears in mind the organic and functional disturbances they may create in the sexual sphere.

The treatment is unsatisfactory. If once the process has become localized in the prostate as foci and nodes, it is very difficult to eradicate it. Medicating the posterior urethra has been recommended with little, if any success. Likewise, massage has proven futile in the majority of cases. Vaccinotherapy perhaps holds out some hope, if used early and systematically. Of late diathermy has been tried, but with indifferent results.

Of late operative interference has been advanced by some as a rational measure, and yet, there are cases where *prostatic drainage* has availed but little and the patient has returned with the same gonorrheal discharge and the nodes still persisting after operation. Enucleation of the gland perhaps is the only logical measure. And yet there are objections even to that, if one bear in mind the functions of the prostate. No man desires to submit to an artificial impotence and sterility, even if the former be only partial in character; in short, he does not want to be unsexed. If we let the process continue unabated, its chronicity may be instrumental in causing enlargement of the gland in advanced middle age, when operation eventually becomes imperative. The treatment is problematical at its best. But if the process tends through its chronicity to induce enlargement of the gland later in life, enucleation is the only alternative.

SUMMARY

1. Gonorrhea is the most common cause of prostatic nodes.

2. By reason of the latter the prostate is altered, both structurally and functionally.

3. The prostatic secretion produced under these circumstances is no longer a normal and physiological secretion.

4. As such it can no longer activate the spermatic fluid and the result may be sterility.

5. Furthermore, the normal prostatic secretion exerts a powerful influence upon virility, and if pathologically altered it may thus cause partial or complete impotence.

6. The prostatic nodes are sources of toxin absorption and responsible for the subsequent train of symptoms thus engendered.

7. The treatment is unsatisfactory and problematical.

THE MICHIGAN STATE MEDICAL SOCIETY—ITS ACTIVITIES AND METHODS

FREDERICK C. WARNSHUIS, M. D.
Secretary-Editor
GRAND RAPIDS, MICHIGAN

The Officers and Council of the Michigan State Medical Society recognize two general, outstanding purposes and obligations: The Education of the Public as to the truths of scientific medicine and what it can accomplish in the prevention and treatment of disease; and, the providing of our members with the opportunity of remaining abreast with medical progress, exemplifying it in their daily practice and enhancing their individual interests.

To attain realization of these purposes the Officers and Committies of the Society have created a group of movements and efforts that develope and institute methods so directed as to fulfill these two general fundamental purposes. Because of numerous inquiries we are presenting these under their designated departments and briefly outline their scope.

JOINT COMMITTEE ON PUBLIC HEALTH EDUCATION

The object of this Committee is set forth in the following declaration:

> "The function of the Joint Committee is to present to the public the fundamental facts of modern scientific medicine for the purpose of building up sound public opinion relative to the questions of pubilc and private health. It is concerned in bringing the truth to the people, not in supporting or attacking any school, sect, or theory of medical practice. It will send out teachers, not advocates.

The Committee is constituted from four representatives of the State Society, four from the University of Michigan and one each from the following state organizations: Detroit College of Medicine and Surgery, Dental Society, Nurses Associations, Department of Health, Tuberculosis Associations, Welfare Association, Board of Registration in Medicine, Wayne County Medical Society, Hospital Association, with President C. C. Little of our University as the active Chairman of the Committee.

A corps of some 300 speakers are enrolled, each is assigned from one to three medical subjects that form the basis for his public address.

Bookings are made by the Extension division of the University. Meetings are sponsored by Parent-Teachers Associations, Luncheon Clubs, Granges and similar lay organizations.

During the past year 480 public meetings were conducted and attended by 184,000 laymen. This work has been continued for the past five years. At times the demand for speakers is greater than the supply. No charge is made to the sponsoring organization for a meeting. The State Society defrays one-half of the actual traveling expense of the speaker.

It must be apparent that this is an achieving form of public education.

LEGISLATIVE BUREAU

In conjunction with all other medical organizations we approached each session of the legislature with some trepidation. There is some wholesome legislation that is greatly to be desired and also pernicious legislation to be opposed. In the past each organization in the state concerned with health, medicine and sanitation submitted its own desires and opposition independently.

This past year, the State Society called a conference to which each organization in the state that dealt with matters pertaining to health, preventive medicine, sanitation and actual practice were invited to send representatives.

Some hundred individuals attended this conference. It was pointed out that cooperative unity and support from these combined organizations whose interests and objects intermeshed would simplify our legislative work as well as strengthen our appeals, representations and opposition.

As a result of this Conference a Legislative Bureau was constituted from representatives of the following state bodies: State Medical Society, University, Detroit College of Medicine and Surgery, Department of Health, Hospital Association, Dental Society, Nurses Society, Welfare Department, Tuberculosis Society, Pharmacists, Crippled Children, and State Board of Registration in Medicine. Dr. Haze,

chairman of our Legislative Committee and Dr. J. Vanderslice were elected Chairman and Secretary of the Bureau. The policy adopted was that each organization proposing legislative bills should submit them to the Bureau for review and approval. Second that the combined membership strength of all organizations constituting the Bureau would be utilized at legislative hearings. It is quite apparent that the Bureau will reflect a potent influence in medical and health legislation and be in a position to arrest impressively the acts of our legislators.

POST-GRADUATE CLINICAL CONFERENCES

For the past 12 years the State Society has been concerned with the scientific programs of our county units and sought to cause them to provide for the individual members opportunity to remain abreast with medical progress. Clinical teams were organized and made available for County programs. District Councilor meetings were conducted. In 1925, the Secretary's office was directed to conduct two, one-day Post-Graduate Clinical Conferences in the fourteen Councilor Districts of the state.

These programs opened at 9:00 a. m. on the designated day and are carried through into the evening. The topics were prearranged and included the entire field of medicine. Thirty minutes were allowed to each speaker who was selected because of his teaching ability and experiences. At noon an hour and a half was devoted to a get-together luncheon and discussion of organizational work of the district. Arrangements were also made for one or two speakers to address the local high school students. In the evening a Public Health Education meeting was conducted.

During 1926 fourteen such conferences were held and forty-four speakers participated in these programs.

In November, 1926, with the aid of our University Hospital Staff a two and one-half days Clinic was conducted at the University Hospital. Some 600 members registered.

In 1927 it is purposed to continue these District Conferences and in addition to extend them to counties. We believe we have demonstrated the need of a Post Graduate School and are now urging its organization so that our members can pursue post-graduate study, and by interrupted attendance pursue a definite course during a given year.

The State Secretary's office also undertakes to meet requests from county societies for speakers for their local programs.

Several of our larger hospital staffs are being supported in conducting stated Clinical Days for the benefit of all physicians in their immediate vicinity.

It is along these lines that we are affording our members means for acquiring practical knowledge to remain abreast of progress and to exemplify that knowledge in their daily practice. Expenses are born by the State Society. There are no additional fees.

ENDOWMENT FOUNDATION

Mindful of our educational obligation and realizing that the coming years must witness still greater extended efforts, on January 1st, 1927, trust agreements were entered into creating an Endowment Foundation. Its purpose is indicated by the following paragraph of the agreements.:

> The purposes of this trust are to pay the net income of the fund or funds held in trust on the written order of the Executive Committee of the Council of The Michigan State Medical Society, for the purpose of providing post-graduate instruction without fee for those designated by said Executive Committee, to conduct clinics and courses of instruction without fee in hospitals and medical schools in the State of Michigan, and to provide funds either by gift or loan to sustain such persons as designated by said Executive Committee, during the period of attendance on said post-graduate instruction or said clinics.

MINIMUM PROGRAM FOR COUNTY SOCIETIES

For a number of years we have noted that County Societies varied in their activity influenced by the election of new officers. They manifested excellent scientific work and concentrated upon it, eliminating other obligations as well as neglecting opportunities of community education and economic advancement.

To overcome such seemingly haphazard undirected policies a minimum program for County Societies was formulated as follows:

A MINIMUM PROGRAM FOR COUNTY MEDICAL SOCIETIES

Section 1. *Scientific*—

(a) Ten meetings are to be held during the year. Local speakers are to appear before three meetings with definite planned discussions.

(b) A program of physical examinations shall be instituted in which all physician members shall agree to have a complete physical examination themselves and each shall agree to secure at least five patients who will agree to have complete physical examinations.

Section 2. *Social and Informal Activities*—

Each Society is to have at least three dinner meetings. The speakers for these meetings shall be public speakers, educators, financiers, but not medical men. At least one picnic shall be held. At least one social evening, in co-operation with

members of closely related organizations shall be arranged.

Section 3. *Scientific Teams*—

Each Society shall have a group of two or three members who will prepare a program and give it on request before at least three other societies.

Section 4. *Public Health Information and Education*—

Each Society shall plan to have at least one Public Health lecture group which shall give at least five lectures in cities and communities outside of their resident communities or cities. Adjoining counties are to be included. Each Society shall co-operate and assist other organizations so that the following public lectures may be held. (Co-operation shall be established with the Extension Department of the University of Michigan, and the Joint Committee on Public Health).

1 Lecture for each High School.
1 Lecture for each Parent-Teacher Ass.
1 Lecture for each Luncheon Club.
1 Lecture for each Woman's Club.
1 Lecture for each Association of Commerce.

Section 5. *Publicity.*

Each meeting, scientific or public, shall be reported to the local newspapers in such form that at least one important point of value can be read by the reader.

The Secretary shall report each month to the State Medical Society the complete record of all activities and accomplishments.

During 1926 fifty-one of our County Societies adopted and carried out this program. In 1927 we hope to record 100 per cent observance of this program.

At the present time there is in the course of compilation a manual for County Society Guidance that will impart plans and policies of Committee Activity. By means of this manual we hope to stimulate greater achievements through standing committees and by reason of committee memberships to enroll more of our members in the ranks of actual organizational workers.

COUNCIL CONFERENCES

During the stated meetings of our Council, one evening is devoted to a Conference Dinner. By way of illustrating the purposes of such dinners the minutes of the last dinner is briefed. The Council invited as its guests representatives of our Medical Schools, Board of Registration in Medicine and State Health Commission; some forty-five members attended. Designated speakers discussed Medical Education, Hospital Internships and Medical Practice laws. Existing problems were cited, intimate information imparted and policies of co-operative support and purpose was outlined.

These Conference Dinners are bringing about clearer conceptions of existing conditions while they also create a spirit of inter-related responsibility. A harmonious relationship ensues. Much benefit and profit accrues from these get-together discussions.

HIGH SCHOOL LECTURES

To extend our public health education, and also seeking to cause the coming generation to have a basis of sound knowledge as to scientific medicine, the State joins with the Extension Division of the State University in conducting during each year a series of lectures before high school students. The Extension Division arranges for the dates of these High School Assemblies in eight of our larger cities. Each school has from 5 to 10 lecture hours during the school year. The State Society with the local county society provide the speakers and formulate a synopsis of the talks scheduled. In the City of Detroit, the Wayne Medical Society has assumed this work. The number of high schools where these lectures are given is being increased each year. This year we are making a trial in two so-called rural counties in order to make observations with a view of statewide extension for this educational movement.

PERIODICAL PHYSICAL EXAMINATIONS

As indicated in our Minimum Program, this national movement is sponsored, applied and directed in our State.

The American Medical Association Manual was not distributed by mail. A special or regular County Society meeting was designated. One or two speakers were then sent to the meeting to discuss Periodic Physical Examination and to demonstrate upon an adult the actual method of conducting a thorough examination. The Manual was then given to each member in attendance and as these meetings were featured by special notices a good attendance ensued. It has been found that it was more effectual than utilizing the mail where the possibility exists of a doctor never opening the envelope.

We also arranged with a Stationary supply house for a leather loose leaf binder, indexed, and 100 examination blanks properly perforated and with a more suitable heading at a low net cost. These we send to members ordering. In this manner we have provided a suitable filing system overcoming an objection that was frequently raised. Incidently at our last annual meeting a member took us outside and showed us a standard $1,800.00 sedan that he had recently purchased from the fees obtained from conducting these examinations among his practice—illustrative of what may be accomplished.

CONFERENCE OF COUNTY SECRETARIES

We recognize the responsibility of County Secretaries and the importance of that office. Annually all our County Secretaries meet for a days Conference. These Secretaries' Meetings enable the Council and officers to outline more effectively our ideals and policies as well as to indicate methods of work for their attainment. We have felt the value of these contacts. The travel expense is paid by the County Society and the local hotels and meals are provided from state funds.

MEDICO-LEGAL DEFENSE

For some 17 years, legal defense against mal-practice has been a membership benefit. Two dollars from the annual dues is appropriated for this work. At no time has there been a yearly deficit. On January 1, 1927, this fund had a reserve balance of $9,300.00. Our results and splendid service is due to the functioning of the Chairman of our Defense Committee, Dr. F. B. Tibbals of Detroit who has served in that capacity from the inception of this legal protection.

We pay no judgments. We defray all court expense and attorney fees.

DUES

Our Annual Dues are $10.00 per year. There can be no extra assessments. Our membership total is 3,065. On January 1, 1927, our net worth was $24,052.41. The monthly State Journal subscription is included in the dues.

The Secretary-Editor receives an annual salary and is supplied with required stenographic service, office rent, light and telephone. Councilors receive actual travel, hotel expense for all but the Annual Meeting. Expense of all committees and committee members are defrayed. Our annual meeting expense is paid from State funds. Two years ago we discontinued exhibits at the annual meeting. Our income is derived solely from dues, advertisements and interest earnings from invested funds.

THE JOURNAL

The past year witnessed the completion of the twenty-fifth volume—a quarter of a century of publication life for our State Medical Journal. It is sent to every member in good standing. The average monthly issue is 3,300 copies—averaging 90 pages per issue. Cost of publication in 1926 was $14,128.32, the subscriptions and advertisements yielded $16,106.40, thereby establishing a Journal profit of $1,978.08 for the year.

INVESTIGATION OF LAW INFRACTIONS

During the past year we undertook to investigate illegal practitioners. The Council felt that it was germane to also concern ourselves with the economic interests of our members and to inquire into the violations of our medical laws. An appropriation was made; a special investigator has been employed and is now engaged in this work.

SURVEY OF THE STATE

During 1926 a survey of the State was made to determine the location of doctors in relation to the population and the public need. The findings have been published in the Bulletin of the American Medical Association.

TRAINING FOR LABORATORY TECHNICIANS

During 1926, as the results of several conferences with the President and Faculty of our Michigan State College at Lansing, a college training course was incorporated in the educational program of that College for students desiring to become laboratory technicians. A need was felt for such a course in order that our hospitals and clinics be supplied with trained workers. During this, the first year, twelve students are enrolled in this three year course. As far as we know this is the first college in the country proffering such training.

WOMEN'S AUXILIARY

We have not been unmindful of the possibilities to be derived from a Woman's Auxiliary. Up to the present time it was felt that our problems required so much supervision that it would be wise to postpone the formation of a Woman's Auxiliary. We feel that the time has now arrived to undertake perfecting such an auxiliary. Consequently during 1927 we are hopeful of instituting a Woman's Auxiliary in every county and are now engaged in its accomplishment.

SURVEY OF MEDICAL CHARITY

In Michigan as well as in all other states abuse of medical charity is not only palpable but increasing. Especially is that true in regard to Hospitals. In order that intelligent consideration may ensue and a policy be adopted, a special committee has been appointed and assigned to make a critical survey and study of medical charity. The further instructions to the Committee are that they shall bring in recommendations as to policy in order that our State Society may go to our Hospital Boards and Clinics with a workable plan

that will minimize this abuse and socialistic trend. The committee is to present its report at our Annual meeting in June 1927.

MORTALITY RECORDS OF THE STATE

In as much as mortality rates reflect to a degree types and efficiency of medical service and practice we interested ourselves in the compilation of these mortality rates by counties. Splendid assistance was rendered by our Health Commission's Vital Statistics Department and death rates were obtained on pneumonia, typhoid fever, cardio-renal disease, heart diseases, diabetes, maternity, still births, puerperal fever, hernia, infant, appendicitis and intestinal obstruction. Some very interesting figures were secured. These were referred to county societies with the recommendation that they review them together with surveying local factors in order that the required steps be taken to reduce these mortality rates. This information also enables us to better determine subjects to be assigned to essayists appearing upon county programs. We consider this project as exemplifying constructive assistance for the elevation of medical practice and efficiency on the part of our members.

STANDING COMMITTEES

Time was when we had a host of committees—some worth while and others existing in name only. As we progressed in our centralization of executive activity many of these committees were gradually eliminated. At present we have the following Standing Committees:

Public Health:

Cooperating with State and Local Health agencies.

Legislation and Public Policy:

All Legislation.

Tuberculosis:

Uniting with and advising the State Anti-Tuberculosis Society.

Venereal Prophylaxis:

Ready to be abolished as its function is now assumed by the Health Authorities.

Civic and Industrial Relations:

Object is apparent from its title.

Joint Committee on Nursing Education:

Associated with similar appointees from Hospital and Nurses organization for study of nursing problem.

Medical Education:

Complying with the function of American Medical Association Council on Education.

Medical History:

Compiling a medical history of the State.

Medico-Legal:

Providing Defense in mal-practice suits.

Hospital and Charity Survey:

Study of the problem of abuse of medical charity.

ANNUAL MEETING

Our annual meeting is held as a rule in September. The session is of three days duration. The first day is consumed by the deliberations of the House of Delegates that completes its work in three sessions presided over by a Speaker. The remaining two days are consumed by the scientific program of section meetings, of which there are five, and general meetings. All the expenses of the annual meeting are defrayed by State funds relieving the entertaining county society of financial burdens.

COUNCIL AND EXECUTIVE COMMITTEE

Our state is divided into fourteen councilor districts, thereby creating a State Council of fourteen members with the President, Treasurer and Secretary-Editor as ex-officio—. The entire Council meets in two regular sessions during the year and sometimes a special session. In previous years, up to 1925, in the interim, the entire executive administration responsibility rested upon the Secretary. In 1925 we recommended the creation of an Executive Committee which was adopted, thereby creating an Executive Committee of the Council, composed of the Chairmen of the Council's Standing Committees—Finance, County Society and Publication—together with the Chairman of the Council and the Secretary-Editor.

This Executive Committee of five members meets monthly. Problems arising from the administration of our general program are discussed and proceedures determined. This plan has proven to be a very wise one and a material factor in the recording of that which has been accomplished. Minutes of the Executive meetings are mailed to each Councilor for approval and when indicated mail votes are obtained.

MISCELLANEOUS AND SECRETARIAL DUTIES

We iterate and re-iterate that the Secretary's office is for service at all times to our members. We invite and encourage submission of inquiries and problems as well as expression of opinions. We en-

deavor to impart requested information or refer them to authoritative sources. Consequent to this policy the Secretary's office finds a growing correspondence that is considered salutary in as much as it enables us to maintain an intimate contact with our members that permits us to sense their wishes and meet their desires. Our central offices strives also to maintain close liason with all state organizations concerned with health and medicine and foster the spirit of their looking and appealing to our State Medical Society in all matters pertaining to our profession in this State.

Lastly, our records, correspondence and financial interests are kept in accurate condition and subjected to annual audit by certified accountants.

CONCLUSION

The foregoing narrative is not to be construed, or appraised as being perfect or the last word. Our methods are imparted for the information of our members and Sister State Societies. It is hoped that other states may do likewise in order that all may gain ideas from such an interchange of information. We are frank to admit that there is opportunity for criticism and improvement. We have not reached the ultimate of perfectness—there is still much remaining to be done and additional service to be rendered. While minor details have been omitted, still on the whole this is a fairly complete description as to how the Michigan State Medical Society is justifying its existence and the objects that govern its organizational activity.

PITUITARY GLAND

J. M. NIELSEN, M. D.
BATTLE CREEK, MICH.

This article represents the present status of our knowledge of the pituitary gland as gleaned from the literature on the subject. An effort has been made to include all that is probably established, seen from the clinical, not the academic aspect.

Discussion of the embryology and anatomy is omitted, as this is easily obtained in any text book on the subject.

PHARMACOLOGY

1. *Anterior Lobe*—A concentrated substance known as tethelin has been isolated from the anterior lobe. This has all the physiological properties of the whole anterior lobe, but is probably not a chemical compound, rather a mixture. Either tethelin or the whole anterior lobe, if fed to young animals, accelerates growth but decreases ovulation. It gives rise to sexual precocity. These two statements seem somewhat conflicting, but this is possibly due to the fact that we are dealing with both internal and external secretions in the sex glands. Tethelin also stimulates the growth of carcinoma cells and tissue repair.

2. *Posterior Lobe*—The solution known as Pituitrin contains the active substance or substances from the posterior lobe. Authorities are still divided on the question of whether there is one single substance or whether there may be as many as four distinct chemical compounds.

(a) *Action on Muscle*—Pituitrin contracts all non-striated muscles with apparently a few exceptions. These exceptions are what prevent us from making the statement that the action of pituitrin is evidently on smooth muscles and not on nerve fibers. The outstanding exceptions are that it slows and strengthens the heart muscle, dilates the pulmonary arteries, probably dilates or at least does not contract the renal arteries and also has a slight mydriatic action. Its action is not consistent with that of sympathetic stimulation because it constricts the bronchioles as it does most other non-striated muscles whereas stimulation of the sympathetic fibers causes dilatation of the bronchioles.

(b) *Action on the Kidneys*—It has both a diuretic and an antidiuretic action. The former appears to be through a direct action on the kidney cells. The antidiuretic action is said to be mediated through the sympathetic fibers. This is supposed to be the mode of action of pituitrin in preventing the enormous output of urine in diabetes insipidus.

(c) *Action on the Respiration*—Its action on the respiration is merely caused by its action on the bronchioles, diminishing respiration through constriction of the bronchioles.

(d) *Metabolism*—Pituitrin stimulates glycogenolysis through its action on the liver and antagonizes the action of insulin. Injection of insulin increases the secretion of pituitrin. The pituitary may thus come to the rescue in case of insulin overdosage.

PHYSIOLOGY

The physiology has been extremely difficult to determine due to the minute size of the intermediate lobe and tuberalis.

Even the functions of the anterior and posterior lobes, however, have not been entirely determined. The authorities, in general, agree that the anterior lobe controls the skeletal development and has a great influence on the sexual functions. Also that the posterior lobe has considerable influence on the blood pressure, metabolism and glucose tolerance. There are other points which have not been assigned definitely to any particular lobe, but are ascribed to the pituitary in general; such as temperature, adiposity, general strength, wakefulness, drowsiness, heart rate, etc. Harvey G. Beck, writing in "Endocrinology and Metabolism," in 1922, states that in dystrophia adiposo genitalis, the deficiency of the anterior lobe causes skeletal hypoplasia, genital hypoplasia, hypothermia, adiposity and cachexia, and that the posterior lobe deficiency causes increased glucose tolerance, lowered metabolism, hypotension and asthenia. Cushing, on the other hand, ascribes adiposity to posterior lobe deficiency. Animal experiments it seems will give rise to adiposity after partial ablation of the anterior lobe. In 1924 Englebach, of St. Louis, summed up the situation as follows:

"There is, however, a great deal of contention regarding the etiology of adiposity. Professor Arthur Biedl, of Prague, is much inclined to attribute these obesities to a cerebral or hippocampal lesion. B. A. Houssay, of Buenos Aires, is more inclined to believe that he has proven experimentally that the lesion is located in the interpeduncular neighborhood of the pituitary gland, but not in the hypophysis itself. Aschner, of Switzerland, claims that lesions of the tuber cinereum have produced this classical type of adiposity in animals. Bremer, of Antwerp, and Baily, of Boston, also are inclined to attribute these obesities, as well as other so-called hypophyseal signs, to extra-pituitary lesions of the hippocampal region. The French school, led by Camus and Roussay have maintained for many years that lesion of the hypophysis does not account for this type of adiposity nor for some of the other symptomatology attributed to the pituitary gland, and relate them to perihypophyseal lesions. Professor Julius Bauer, of Vienna, gives to the primary inherent gamete and zygote cells the property produced by chromosomal deficiency, the etiological factor in the production of adiposity. He claims that if the individual cells producing this panniculus were dissected off one portion of the body, the hips, for instance, in the pituitary case, and engrafted upon the back of hand or the supraclavicular region, they would continue with the overgrowth and production of the adiposity.

"Contrary to all this contention and, for the most part, physiological proof in animals, we have continued to believe that the majority of these juvenile obesities are due to internal secretory disturbance and that the adiposity in these particular cases is caused by deficiency of the posterior lobe of the pituitary gland. It cannot be disproved, however, that the function of this portion of the gland may not be influenced by lesions or nervous impulses coming from various portions of the brain, hippocampal gyrus interpeduncular region, tuber cinereum, etc."

PATHOLOGY

Malformation of the pituitary is not at all uncommon. These malformations appear to affect the anterior lobe more than the posterior, due to the peculiar embryology of the anterior lobe. On account of its central situation, the sella turcica is frequently damaged by trauma to the head in general. After the age of forty, circumscribed adenomatous growths are common within the anterior lobe. These do not necessarily give rise to acromegaly. Hemorrhage into tumors of the pituitary is common. Infarcts are fairly common and cause the usual hypofunction syndromes. These of course, affect the anterior lobe more than the posterior, but an anterior lobe lesion practically always affects in some way the posterior lobe. It has usually been found that the hypophysis enlarges in cretinism and myxedema. Experimental removal of the thyroid causes enlargement.

Castration causes an over action of the pituitary with the usual hyperpituitary symptoms. The pituitary is influenced by lesions in other glands of internal secretion in general. These are not definite enough to be outlined dogmatically.

ACROMEGALY

Acromegaly means large extremities. The disease was so named because the obvious pathology affects mostly the sharp edges of the terminals; that is, prominent features of the head, and the hands and feet.

1. *Etiology*—Acute infection seems to predispose to hyperactivity of the pituitary, and as the gland enlarges in pregnancy, some authors claim that pregnancy is etiological. Heredity, trauma and fright,

all have been blamed, but probably play no role.

2. *Pathology*—The fundamental pathology is a proliferation, usually adenomatous, of the acid staining cells of the anterior lobe. There is, however, much accessory pathology, the most outstanding of which affects the periosteal osteoblastic cells at the site of insertion of the muscles. This is of great importance in understanding the osseous pathology of acromegaly. The bones increase where muscles are inserted and, in general, do not increase at other points. Thus the superciliary ridges are enlarged at the site of insertion of the frontalis muscle, the lower jaw is large at the sites of insertion of the masseter muscles and the nose is broadened due to the insertion of the muscles at the angle of the nose. The soft tissues also increase very definitely in size. In all this increase, there is a tendency toward masculinity. The skin becomes thick, hairy, greasy and pigmented. The genital effects are toward masculinity ;that is, the clitoris is enlarged, amenorrhea ensues.

3. *Symptoms*—The symptoms are divisible into three stages; an active stage, a so-called characteristic second stage, and the stage of hypopituitarism.

(*a*) *Active Stage*—This is the stage at which a diagnosis should be made if possible, as this is the golden opportunity for treatment. This stage may last only a few weeks or several months. It is characterized by pituitary headaches which are intermittent in character and usually located by the patient in the head biteporally or at the top, somewhere deep in the head, and not frequently is related to meal times, in this way, that the headache is apt to disappear after a full meal. There is increased libido. Males find themselves impelled by a force not under their control and find it extremely difficult to suppress the sexual desire. There is increased strength commensurate with the increased irritation at the sites of insertion of the muscles. There is frequently glycosuria and polyuria. A characteristic complaint is pain in the face. This pain may be burning, scalding or neuralgic in nature and persistent. It is described by patients as though the eyes were too large for their sockets, as though the muscles were being pulled. As only two of these symptoms, the pituitary headaches and pain in the face are symptoms of which the patient will complain, it is obvious that those complaints should arouse suspicion of the onset of acromegaly. Right treatment at this point may prevent the entire syndrome from reaching any further stage of development.

(*b*) *Second Stage.* 1. *Osseous*—This is the stage in which the characteristic symptoms are evident and in which a diagnosis is possible on inspection. Practically all the bones, but especially those in the extremities where muscles are attached, increase in size; not in length, but in thickness. The jaw presents the most striking feature, becoming very prominent and undershot. This gives rise to a separation of the teeth as the jaw proliferates while the teeth do not. The nose becomes very broad, the larynx large, giving rise to a deep voice. The sternum and upper chest increase, causing barrel chest and kyphosis. The hands and feet increase especially in breadth.

2. *Soft Parts*—In general, here again, there is a masculine conformity. And while the muscles are enlarged, the patient becomes feeble as the strength does not continue to be commensurate with the increase in size. The lips become very thick. The genitals atrophy. Muscles of the hands and feet are large in size, but weak. The tongue becomes thick and broad. The heart and blood vessels increase in size to keep up with the increase in general build.

3. *Skin*—The dermis, epidermis and subcutaneous tissue all increase. Sweat glands proliferate. The skin thus becomes greasy and lies in folds. There is a general increase in hair over the body. In the female this is especially noticeable, hair extending up over the abdomen in the midline and over the chest; the skin becomes dark and perspires.

4. *Genitalia*—In this stage are found impotence, sterility and amenorrhea.

5. *Metabolism*—There is a low sugar tolerance though not necessarily glycosuria. There may be a high blood pressure. There is retention of nitrogen and phosphorous in the blood.

6. *Nervous System*—The symptoms referable to the nervous system are those in general of a neurasthenic state; photophobia, lassitude, depression, loss of interest, lack of concentration, indecision, irritability and distrust are common.

(*c*) *Third Stage*—The third stage is characterized my the hypopituitary syndrome and sometimes by cachexia. The cachexia consists of tremors, twitchings, insensitiveness, slow pulse, low blood pressure, low temperature, apathy, even coma and death. The hypopituitary syndrome

is that of dystrophia adiposogenitalis and will be discussed under that heading.

DYSTROPHIA ADIPOSOGENITALIS

The striking features of this syndrome are adiposity, especially of the girdle type, and hypoplasia of the genitalia. There are a number of possible causes for this condition. As it is the terminal stage of acromegaly, this should be considered in the etiology. Other causes are syphilis, brain tumors, hydrocephalus from any cause, hemorrhage and infarcts into the pituitary, many non-specific lesions, such as injuries, and there is a large idiopathic group.

SYMPTOMATOLOGY

The symptomatology is characteristically toward feminism, no matter which sex the patient may be.

1. *Osseous System*—Referable to the osseous system occur broad pelvis, lordosis, genu valgum, slightly tapering fingers, skeletal underdevelopment in general, prognathism, feminine voice, small head, small interpupillary distance, broad and malformed teeth.
2. *Metabolic*—Under the general head of metabolism are found a lowered basal metabolism, pelvic girdle type of adiposity and high glucose tolerance.
3. *Genito-Urinary* — We find hypoplasia, impotence, sterility, amenorrhea, loss of libido, feminine breasts, polyuria, the diabetes insipidus syndrome and vesicle irritability.
4. *Skin*—The skin is dry, thin, transparent. It has been called the peaches and cream complexion. The crescents on the nails disappear and there is a generalized hypotrichosis.
5. *Nervous System*—Subnormal mentality is the rule. Mild psychosis or convulsive seizures, inability to concentrate and impairment of memory are found.
6. *Miscellaneous Items*—There are a few miscellaneous items as low blood pressure, constipation, polydipsia and drowsiness.

TUMORS

While tumors may be the cause of acromegaly or dystrophia adiposogenitalis, a discussion of these has been omitted under those syndromes because when there are symptoms of tumor, that is, persistent neighborhood or pressure symptoms, the case becomes one of tumor to be treated as such rather than a mere syndrome. The symptoms of increased intracranial pressure will sooner or later occur in all of these ;namely, dizziness, headache, vomiting, disturbance of pulse, choked discs and stupor. Symptoms due to the anatomical location of the tumor occur as visual disturbances, especially bitemporal hemianopsia or any form of field distortion, optic atrophy, anosmia, exophthalamos, eye palsies, uncinate fits, pyramidal tract symptoms and, peculiarly, epileptiform seizures. This group of symptoms may then complete many of the well known syndromes or may appear to be the primary difficulty.

MIXED SYNDROMES

While most space is allotted to the characteristic syndromes described, there is no doubt that the number of cases of mixed dystrophy of a much milder character are far more numerous than those of classical syndromes. We merely say less about them because they are partial syndromes, difficult to diagnose or difficult to treat. Timme of New York, who has done a great deal of work in this field, outlines three definite syndromes referable to the pituitary in which he finds therapy especially valuable. They are:

1. Deficiency secondary to other glandular difficulties, castration, puberty, menopause or oophorectomy.
2. A compensatory syndrome group characterized by hypoadrenalism or status thymico-lymphaticus.
3. In the goitre belt, thyroid insufficiency.

One symptom is also said to respond well—the pituitary headaches when not based on tumor.

DIABETES INSIPIDUS

In view of what has already been said about the anatomical location and the influence of the tuber cinereum in pituitary syndromes, very little need be said about diabetes insipidus. This syndrome is known to be easily producible by a lesion of the hypothalamic region as well as by a lesion of the posterior lobe of the pituitary.

THERAPY

In acromegaly the hyperactivity of the pituitary in the primary stage very definitely contraindicates glandular therapy. It is possible that a little relief may be obtained in the third stage when a hypopituitary syndrome has become established. This, however, would give the patient but little relief.

In the adiposogenitalis syndrome, the concensus of opinion is that both lobes are involved and therefore whole gland administration is indicated. Strange to say,

thyroid administration seems to be of even more importance than pituitary in the treatment of this syndrome.

In the above three groups ??????? by Timme the whole gland is given in dosage from 1/10 to ¼ of a grain once a day or twice a day, omitting it if headache results and every fourth or fifth day in any event. In administering pituitary substance it seems to be the concensus of opinion that results may be obtained by administering anterior lobe by mouth, preferably on an empty stomach, that is, before meals. Posterior lobe extracts have very little effect by mouth and should be given by hypodermic administration.

There is no need in discussing here the various surgical approaches as this is always left to the particular surgeon who may be called upon to operate.

X-ray treatment in the active stage of acromegaly is of definite value, also in other carcinomatous or adenomatous growths. Decompression to aid X-ray penetration is practiced. The usual discussion arises as to the preference for surgery or X-ray treatment in malignant growths.

SOME PSYCHOLOGIC PROBLEMS IN OTO-LARYNGOLOGY*

BURT R. SHURLY, M. D.
DETROIT, MICHIGAN

Psychology as applied to the every day affairs of life is constructive or destructive. When the latter variety is in the overwhelming majority an analysis is required to turn the tide back to the place where it rightly belongs in the medical profession.

We can be satisfied in our specialty with nothing less than 95 per cent constructive psychology. As a factor in the recovery of our patients it stands out pre-eminently in the front rank and as a promotor of harmony and good will nothing can supplant the constructive and optimistic mental state. It must be taken for granted that ordinary skill or better is exercised at all times.

The facts of the importance of constructive psychology in contra-distinction to those of the destructive variety are well recognized by each man who gives the matter consideration, but is it not true that the exercise and application of this wonderful spirit of support, co-operation, and loyalty, to the cause is in a state of slumber in some of our medical centers.

It is my belief that this Society stands out preeminently advocating and practicing this spirit of good fellowship, harmony and earnest scientific endeavor. Honest criticism has its place and value and may offer much along lines that are upbuilding and uplifting but hypercriticism of the methods of hospitals and specialists in the presence of the laity is far reaching and often misinterpreted. If we have nothing good to say of an operation, a result or a criticism, silence was never more golden. The art of the management of the patient is second only to the art of oto-laryngology.

The literature of our specialty is profuse in a splendid scientific story of the progress and achievements of surgery. Numerous operations with a refined technic, tons of highly specialized instruments, often with slight modification, with or without value adorn our offices and silently speak of the enthusiasm of a creditable inventive genius that is in our midst.

Yet the great psychologic field of therapeutic endeavor that so greatly influences the results of our practice is given comparatively little attention in medical education or post-graduate instruction. For this reason alone that sufficient interest and study are not given to the management of the patient and consideration of his mental state, the cults of Christian Science, Osteopathy, and the like are sought in response to a longing for someone to lean on who will give a responsive ear and the requisite sympathy to a tale of woe.

Those of us who were trained through the field of general practice, who made calls with a preceptor and who studied the state of mind in the home and family, learned many things about sick people that apply to the art of oto-laryngology and that no highly technical training in college or post-graduate school can entirely supply.

We have always recognized psychologically different types of patients. Those treated in the home and the hospital; the clinic and the private patient. The referred cases and those not. The American and the foreigner. The so-called aristocrat and the pauper. The educated and the ignorant. In addition might be mentioned the conscientious objector who objects to any or all treatment not recommended by himself. Races and creeds have

*Read at the Annual Meeting of the Eastern Section of the American Laryngological, Rhinological and Otological Society, January 8, 1927, Brooklyn, New York.

their peculiarities of management and treatment. Just as the lunger becomes a mental type requiring special mental treatment, so certain classes of chronic deaf, the ozena or hay-fever patients, become mentally peculiar and demand special additional mental treatment.

This is the age of the aeroplane, the automobile, the transcontinental flyer, the ocean greyhound, the auto-bandit, and the movie. This is the age of vibration and storm, the quick lunch and the short sleep. The short skirt and short hair are the rage. A gentle question may receive a burst of anger. A simple request to perform some simple duty may be met with the ultimatum to get some one else. The public and the profession will not wait. The explanation is that the world is irritable, restless, and perhaps less honorable.

We have a psychology before and since the war that is quite changed. Twenty million soldiers learned a state of mind and developed an idea that the cute thing to do in all cases was to shift responsibility or work. In other words, to "pass the buck" was the delight of the soldier and the lowest private carries the burden. I believe this is reflected today on the great American public and has much to do with a lack of responsibility.

At Chicago in 1908 there were present at the American Medical Association meeting 6200. Of this number more than 1,200 were registered in Eye, Ear, Nose and Throat work.

It was estimated by the Medical Department of the Regular Army that 200 beds in a thousand bed hospital should be reserved in time of war for head diseases and injury. In my own hospital, in France, of 3000 beds with 15,824 sick and wounded treated, 27.3 per cent were operated or observed by the head department .

It is fair to assume that one-quarter to one-fifth of disease and injury falls into the domain of head surgery, is it not fair to demand qualifications of high grade.

Another psychological phase of our problem deals with the medical profession as a whole and our specialty in particular. It is thoroughly recognized that the oto-laryngologist must be a well trained surgeon. He must be called on for brain surgery, the removal of a goitre, or ligation of the carotid if he wishes to extend his field, but is it not essential that he should be a physician so familiar with diseases of the chest and internal medicine that he will not operate oto-laryngologic lesions with active pulmonary tuberculosis under ether, and that he will be constantly alert to the fact that more than one-half of all special problems of oto-largngology that are not referred cases, are attended by some associated problem in internal medicine or neurology. The non-referred cases should be more carefully classified by the oto-laryngologist and referred to the proper treatment for the systemic condition.

I believe that under the stress and strain of the constantly increasing high pressure of life with diseases of the tubing increasing 67 per cent in a decade, that a corresponding increase is seen in neuroses, psychoses, and functional disorders in our field of work.

Has the furor of tonsillectomy, focal infection, the crooked septum, and the hunt for sinus disease, obscured a consideration of the ever-present unstable nervous system. Our patients are classified into those with real and imaginative disease.

Is the specialist a tyro who has the courage to sit down and spray the throat of the globus hystericus, apply a galvanic current and with carefully worded suggestion relieve and remove the symptoms that belong in the sub-conscious? Or is the hero, the surgeon who removes the non-pathologic tonsils of such a case, increases the instability of the nervous system and finds them soon in the hands of the osteopath.

If the vast and increasing army of neurotics are to be given relief which they seek first from the regular profession, they must receive more careful consideration and study of the psychic state involved and fewer operations at our hands. By a failure to manage these cases we are rapidly increasing the ranks of charlatanism and the cults. If we have not the time, patience, personal interest and magnetism, to manage this class of ear, nose and throat cases, it is essential that they may be referred to the neurologist with the proper qualifications.

Probably our greatest psychologic error at the present time is the curious state of mind that exists among the profession and the laity with reference to tonsil remnants. Nothing has shaken the confidence of the public in the oto-laryngologist more than the radical attitude of some of our non-diplomatic brothers toward the continuous and recurring secondary tertiary and more operations for tonsil remnants. The absurdity and seriousness of this procedure

psychologically is best illustrated by one of my cases.

I removed the tonsils and adenoids of a five-year old child belonging to a well-to-do neurotic family of a race given to accentuated symptoms. The operation was entirely satisfactory to the family and myself, and strange to relate the fee was also satisfactory. A year later, an interne, student and friend of mine, said he would like to tell me about Dr. A.B.E., who had removed the tonsils and adenoids a second time on the above case and had reported to the family what a wonderful job he had done for a fee equal to the first operation. My interne friend had taken the remnant tissue of the second operation to an expert pathologist and he had found no tonsil tissue present.

Offending tonsil tissue must be removed but the management must be diplomatic, the conversation guarded, and the necessity face evident.

The scientific progress of special surgery in the last two decades has been so rapid and expansive that together with the evolution and revolution of social medicine and the world war it has been imperative that the individual adjust or succumb. Those of us who were satisfied with the methods of prebellum days have adopted the newer classification of our work.

It is true that the laity need instruction and leadership. It is true that prophylactic oto-laryngology and medicine, public health, and hygiene have made marvelous scientific advancement. It is true that medical education and hospitals, under the laws of standardization, have progressed for the benefit of the medical student and the patient, yet State Medicine must not achieve an organization and arbitrary power that sweeps aside the fundamentals and essentials of medical practice, namely altruism, humanitarianism, individualism, the psychology of bedside medicine, the counselor to the mind diseased and distressed. We must beware of too many guinea pig hospitals. A few are sufficient. We must establish and maintain a balance between ultra-specialism, specialism, and general practice, and we must not forget that the practical doctor for the past decades with his time honored preceptor has made, established, maintained, and sustained the honor and glory of the American Medical Profession for more than a century.

The newer surgical method and discovery, the latest invention, in instruments, the fad, fancy, fashion, of some brilliant dreamer does not always prove the winning success that its spectacular literature would lead us to believe.

Those of us who have lived a quarter of a century in the practice of medicine, know the storms we have encountered. We have been tossed on the seas of radicalism and conservatism. We have been criticized and abused and when we landed, shook ourselves, and found both feet on the ground, we learned to know that the land of health and happiness is pierced by a middle road that we now delight to travel.

The flowers of our profession, the general practitioners, may wither and fade while medical education and ultra-specialism with higher and higher standards are creating demands for luxury, diminished labor, less responsibility, more money and amusement.

There are many dangers in this rapidly changing system that will soon surround the medical profession with grave and difiicult problems. Competition is keen. Unjust and hypercriticism are fashionable and the unkind, restless, nervous, spirit of war is yet among the people.

A marvelous change has come over the armamentarium of the laryngologist of two or three decades ago. A laryngoscope, a galvanocautery, a Matthews tonsillotone, a Jarvis snare, and a few spray bottles would make a busy specialist. He is now a department. Scientific progress and public demand have required the nurse, the assistant specialist, the special hospital and laboratory, and the physio-therapist. It is rare indeed, in our large cities that tonsillectomy, mastoidectomy, or many minor operations are performed without operating room facilities. This is as it should be.

We must realize that the modern patient is impatient, hypercritical, unstable, and changeable. The doctor of today is not his of tomorrow. The law of obligation, the mere matter of appointments at the office or for operation, are more often broken, bills are more frequently returned with the postmaster's notation—"left no address." Appreciation of professional service has diminished and the wise counsel of the experienced practitioner is turned aside for the fad of the osteopath. The fashionable clique change their doctor for one more fashionable. The fault is within ourselves.

To meet this new and strange psychology we must establish a remedy that will hold a stampeding, panic-stricken, sick

public until adjustment takes place. Standardization of medical colleges, hospitals and specialists, is great and glorious work, but it is too slow a remedy.

It is true that State, Industrial and Co-operative Medicine have come to stay as definite divisions of medical practice. Their progress is rapid and ominous. The might organizations of State Medicine are rapidly classifying and extending their work. They are building and overbuilding great hospitals with a lavish expenditure of the people's money. They are employing and controlling a mighty army of doctors and nurses. Theirs is a good and noble work, but unless some counteracting force will limit the extravagance and wastage, unless the great medico-political machine will curtail and regulate the wholesale treatment and encouragement of people well able to pay the physician and surgeon, the general practitioner will suddenly awake to the fact that the state competition of clinics, hospitals and consultations, in his own town, supported by his taxes, has deprived him of a chance to live and support his family.

When the boards of health go beyond the police function for which they were originally intended, build pay hospitals and collect for nursing and service they compete with the profession.

With an unswerving optimism and enduring appreciation we look to the younger oto-laryngologist to balance his wonderful training as a skilled technician with the older school of conservatism and bedside psychology, and realize that judgment, experience, intuition, and the art of oto-laryngology, are estimable qualities, attained by long years of toil and mistakes in the operating room and at the bed-side. They are entitled to respect and consideration. Why should the assistant not bide his time? Why should he over-value his services? Why should he expect to attain the position of Chief of Service until experience, judgment, and a few fatal cases, had mellowed a gigantic nerve, an overestimated ability and a dream of One Thousand Dollar Tonsillectomies and Mastoids.

A young man applied to me for the position of assistant some time ago and I asked him two questions. First—What can you do? Second—What is the value of your services? He quickly replied—"I can do any operation and I would require Six Thousand Dollars a year to begin. I have just finished six months in a New York Post-Graduate School, and I have performed seven radical mastoids and am prepared to do major surgery. I would not be interested in minor operations. I have passed all that." I told him I was delighted to hear he was so well qualified and that if he would leave his address, when I retired I might send for him.

As a younger man it seemed to me that veneration, loyalty, love, respect, and appreciation for the chief were essentials of proper co-operation. In the mad rush for money is our psychology changing with that of the patient? Are we losing some of the finer attributes of a success, and if so, can we not call them back? Can we not mingle some of the venerated qualities of the dear old family practitioner, kindliness ,humanitarianism and martyrdom, with the wonderful scientific and educational attainments of the modern oto-laryngologist?

The most renowned and learned professor of the knife is helpless to cure without his patient. The research scholar is useless without his human material. The specialist must have his ear, nose and throat to demonstrate his new operations.

To apply the remedy give us a better psychology to manage, satisfy, and control, the whim, fad and fancy, of the patient. He is our ideal. Our interest, our labor, our thought. Our life is wrapped in his welfare. If he sees more clearly, if he hears more acutely, if he tastes more keenly, if he smells more luxuriously, the pleasure and privilege are ours.

Our oto-laryngologic road may be strewn with myriads of tonsils and septal and mastoid bones but if we conscientiously believe them to be abnormal ones, removed skillfully at a conscientious price, why should we or the world worry?

OCULAR MANIFESTATIONS OF SYSTEMIC DISEASES

EDGAR E. POOS, M. D.
DETROIT, MICHIGAN

The eye is often affected by general systemic diseases, often taking a prominent part in the general process.

Syphilis is very prone to affect the eyes in all of its stages. The primary sore may occur on the eyelids or conjunctiva. In the secondary stage there are generally acute inflammatory affections of the anterior segment of the eye of which iritis occurs in at least 25 per cent of the cases. Inherited syphilis is responsible for the great majority of cases of interstitial keratitis.

In the later stages of secondary syphilis

the posterior segment of the eye becomes affected such as chorditis, optic atrophy, neuro-retinitis, choked disc, opacities of the vitreous, atrophy of retina, iris, choroid, etc.

In the tertiary stage may have gummata deposited in iris, ciliary body, periosteum of orbital wall, diffuse opacity of vitreous.

Palsy of extra and intra ocular muscles are quite common and the typical syphilitic pupil of the eye characterized by inequality, irregularity and immobility or the Argyl-Robertson pupil found in neurosyphilis.

Tuberculosis the last few years has been found to be a frequent cause of eye disease. In the so-called scrofulous or strumous diathesis, presenting a well known clinical picture but indefinite pathology and association with the tuberculous state, there is a predisposition to many common diseases of the anterior portion of the eye, namely, phlyctenular conjunctivitis and keratitis, blepharitis, and interstitial keratitis. Inequality of the pupils are often seen in pulmonary tuberculosis. Tuberculosis is often the cause of affections of iris, ciliary body, choroid and sclera. And in general miliary tuberculosis it is not uncommon to find small tubercle deposits scattered over the fundus.

Brights disease nearly always produces ocular conditions particularly distinctive of it alone.

Puffiness of eyelids upon rising in the morning is regarded as an early symptom of renal dropsy.

Albuminuric retinitis is an early and very characteristic symptom of the condition. It is found in the interstitial variety, also frequently nephritis due to scarlet fever and pregnancy.

Loss of vision complete or partial, may be uremic in character, characterized by its sudden onset, pupils are dilated but react, may or may not have ophthalmoscopic changes.

Exopthalmos is often seen in later stages of nephritis.

DIABETES

The most common manifestations of diabetes in the eye are cataract and hemorrhages in the retina. Diabetics occasionally present sudden and marked changes in the state of refraction of the eye, especially myopia, but also hyperopia accompanying an increase in the amount of sugar in the urine.

Less frequently have retinitis, retrobulbar neuritis, iritis. Sudden amaurosis similar as in uremia, may occur, and in a few cases have paresis of muscles, optic atrophy and paralysis of muscle of accommodation.

Rheumatism is very prone to produce an iritis but may be a factor in producing other ocular conditions such as episcleritis and tenonitis, and palsies of extrinsic ocular muscles.

HEADACHES

Headaches are frequently caused by errors of refraction, anomalies of extrinsic ocular muscles, less often presbyopia and accommodation weakness. The error of refraction most commonly responsible being astigmatism even if only a small amount, but also hyperopia. If the person is in a debilitated condition he will often need glasses which will be unnecessary when health is regained.

Chronic intoxications that affect the eye include alchohol, tobacco, quinine, lead, methyl alcohol, etc., all of which induce chronic retrobulbar neuritis and consequent alterations in the vision especially the fields of vision.

*Infectious diseases are nearly all accom*panied by their characteristic eye changes. Influenza is nearly always accompanied by congestion of the conjunctiva, often having pain in and back of eyeballs, infrequent complications are corneal ulcers, retrobulbar neuritis, optic nerve atrophy and paresis of ucular muscles, also weakness of accommodation and asthenopia due to the depression following the disease. Measles is regularly accompanied by a catarrhal conjunctivitis with subjective symptoms varying severity.

Frequently have a blepharitis, hordeola, superficial corneal ulcerations and asthenopia. Scarlet fever seldom affects the eye early but in later stages corneal ulcerations and inflammations aren't infrequent. If there are renal changes, there are the characteristic eye changes also.

Diphtheria is not infrequently attended by a diphtheritic inflammation of the conjunctiva, but may later have paralysis of one or more of extrinsic muscles of the eye, and paralysis of accommodation.

Whooping Cough is often attended by a subacute conjunctivitis, and a sudden hemorrhage may occur in conjunctiva as a result of severe paroxysms of coughing.

Septicemia and Pyemia display a tendency to retinal hemorrhages and lodgment of septic emboli in the choroid or retina with resulting suppuration of the eye.

Gonorrhea is responsible for purulent

conjunctivitis in adults and ophthalmia neonatorum in the new born. As a result of toxins have a form of iritis resembling rheumatic iritis in some of the chronic gonorrhea cases.

DISEASES OF DIGESTIVE TRACT

Dental affections provoke ocular troubles by (1) Inflammation or irritation of trigeminal nerve causing reflex troubles.

(2) Extension of an inflammatory process of the dental root toward the maxillary sinus, thence toward the orbit by continuity and contiguity of structure.

(3) Absorption of septic material from diseased teeth as in pyorrhea alveoloris. Some of the other conditions associated with diseased teeth are conjunctival congestion, iritis, keratitis, cyclitis, choroiditis, asthenopia, weakness of accommodation, etc.

Blepharospasm and chronic contractions of orbicularis muscle occur as a reflex through the facial nerve.

STOMACH AND INTESTINES

Affections of the stomach and intestines may affect the eyes in four different ways.

1. By general weakness, causing lack of nutrition and alteration of the blood.
2. By absorption of the toxic elements the result of improper digestion and assimilation of food products.
3. By congestion of the brain and organs of vision, induced by circulatory troubles consecutive to abdominal plethora.
4. By reflex irritation of the sympathetic intra intestinal plexus (plexuses of auerbach and Meissner) affecting the organs of vision.

These conditions may cause asthenopia, weakness of accommodation, iridocyclitis, choroiditis.

Hemorrhages in stomach and intestines may cause amblyopia with anemia of retina.

Liver—Jaundice is often first seen in the sclera and conjunctiva in liver conditions.

Respiratory tract—Following serious catarrhal affections of the respiratory mucous membrane often have herpes of cornea especially in pneumonias which may lead to ulceration of cornea.

CONCLUSIONS

All patients with cardio-vascular renal disease, arterial hypertension, diabetes, diseases of blood, skin, tuberculosis and pregnancy should have both external and ophthalmoscopic examination as we often find disturbances in the eye before we have the general symptoms of the condition present.

There should be close cooperation between the ophthalmologist and other branches of medicine and surgery, as most of the diseases have their characteristic eye conditions and often may lead to an early diagnosis.

SURGICAL—DISEASES OF THE GALL BLADDER

C. D. BROOKS, M. D., F. A. C. S.
DETROIT, MICHIGAN

In the last 25 years many advances have been made in surgery, and probably no organ has received more attention than the gall bladder. Formerly it was thought necessary for the patient to suffer months or years from so-called indigestion or neuralgia of the stomach, before he was considered sick enough to have a careful examination. On account of this delay, diseases of the gall bladder and liver, with associated duct and pancreatic disease were often very far advanced before receiving proper treatment.

DIAGNOSIS

While disease of the gall bladder is most common after the age of 40, it is quite common in the second and third decade. We have operated on 20 patients in the last 11 years under 20, the youngest one 14, with a history of gall bladder disease since the age of eight. Gall stones have been found at autopsy in infants. The subjective symptoms of gall bladder disease are often quite characteristic. The earliest symptom is gas distention occuring irregularly without reference to qualitative or quantitative food intake. It is quite common for the symptoms to occur at night several hours after a meal, at times causing enough distress to waken the patient out of a sound sleep. Usually the symptoms noticed early are heartburn occurring for a day or two at a time, and then a lapse of perhaps weeks or months without a return; Usually there is no pain aside from slight distress, but as the disease progresses and the gall bladder becomes distended, and the ducts become blocked with mucous or stones, slight pain or sorness is noticed depending upon the character and amount of the infection present. The pain is usually referred to the scapular region, often mid-scapular, and quite frequently to the left. At the

time of the referred pain, if the patient is carefully examined, usually slight tenderness will be found over the gall bladder. Constipation is a common symptom associated with gall bladder disease. It is quite likely that cholecystitis and hepatitis are present months or years before gall stones develop in most cases, in others, patients have had none of the above symptoms but have a classical attack of gall stone colic, which is the first evidence that they have had a disordered function of this organ.

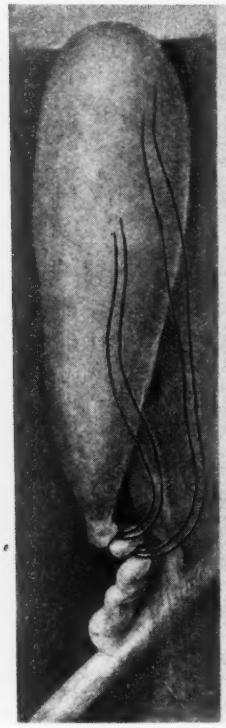


Figure 1
Two sutures are placed and tied lightly around cystic duct

Figure 2
Finger is placed within gall-bladder and flexed, putting tension on cystic duct which is divided above sutures.

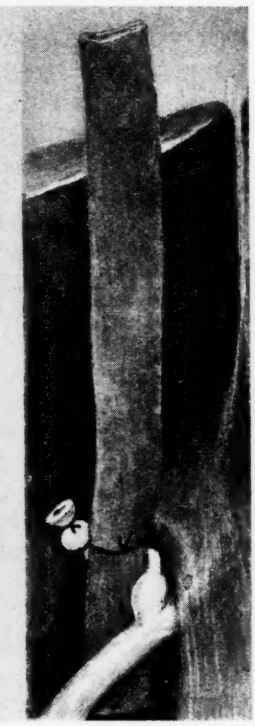


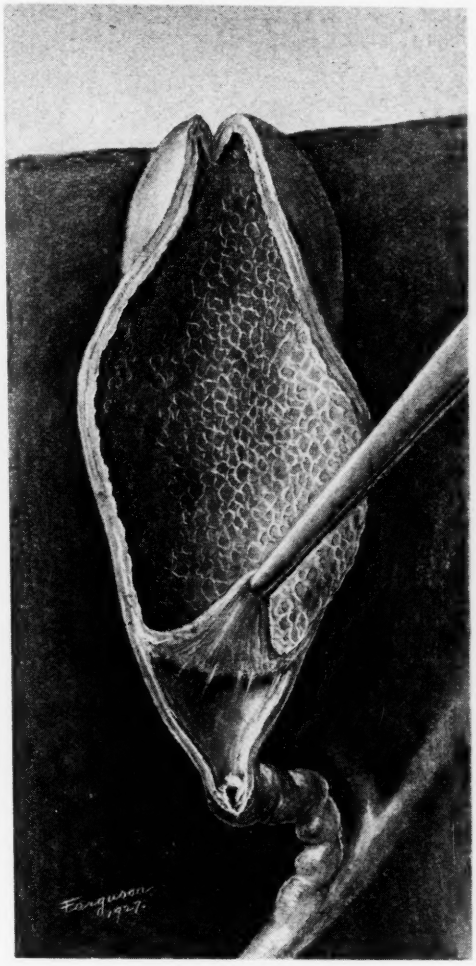
Figure 3
Soft rubber drain is placed below stump of duct and tied lightly in place with ends of lower suture which was tied around duct.

It has not been felt in surgical fields that the Lyon duodenal drainage is of great importance as a diagnostic feature. Its use, we believe, should be left for those cases in which a moderate cholecystitis may be present, combining its use with dietetic and other medical treatment. We believe that the chief value of this duodenal drainage (Lyon) is as a valuable adjunct after both cholecystostomy and cholecystectomy in certain cases. It would seem to be of especial value in those cases of hepatic cirrhosis with biliary obstruction or from common duct obstruction following operation. We have thought it of distinct value, at times, in preparing patients for operation, but we also note a marked danger in long continued treatment with the duodenal tube, and it seems to us dangerous to persist in such treatment unless the patient's relief is very evident. We feel it should not be used excepting to prepare a patient for operation, as early as convenient in cases associated with marked tenderness in the gall bladder area, fever, chills, and the typical gall stone colic, the gall bladder drainage by means of the duodenal tube is distinctly contra-indicated.

In differential diagnosis, ulcer of the stomach and duodenum, and appendicitis causing pylorospasm and disease of the pancreas should be carefully considered.

It is of definite value to note that after cholecystitis is well established that neither qualiatative or quantitative food intake appears to have much influence over the character and time of the attacks. Chronic pancreatitis, we believe to be generally a direct result of chronic cholecystitis, which makes it evident that patients should not be allowed to go a long time without surgical intervention, after a correct diagnosis has been made. Whenever possible, routine blood count and blood clotting time should be estimated, and a Wassermann test made, not forgetting

that a patient with a positive Wassermann can also have cholecystitis, cholangitis and gall stones. A study of the gastric contents may be of value in differential diagnosis, but as a rule we believe it is no particular value as a diagnostic aid in cholecystitis.



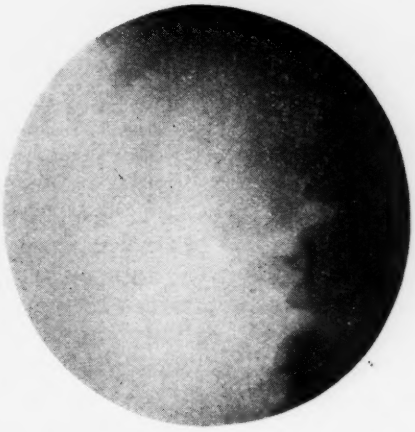
Cholecystectomy in acute cases. Where the gall-bladder wall is edematous or gangrenous, the gall-bladder is incised down to the cystic duct and the mucosa is peeled out.

In medical treatment, it is highly important that all foci of infection such as diseased and devitalized teeth or root abscesses, with diseased tonsils, sinus infections and colonic stasis should be carefully eliminated or treated. We consider it very important that all such factors should be eliminated early in the course of medical treatment. Gall bladder operation should not be performed until at least a month or longer has expired after focus of infection has been removed.

There are various routes of infection in the gall bladder and biliary tract. We believe the most important one is the hematogenous route, secondary to focal infection elsewhere, carried in the form of emboli.

The writer saw three cases within ten days of acute gangrenous gall bladder, following acute streptoccocic tonsilitis. Experiments have also shown that cholecystitis can be definitely produced by injections in the blood of animals by bacteria obtained from an infected gall bladder.

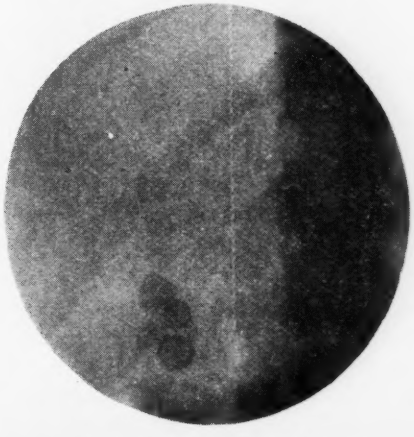
This is one of the reasons why we believe that the appendix should be removed routinely as a part of the gall bladder operation, as it is quite often a primary factor in the cauzation of cholecystitis and associated biliary infections.



Non-opaque single gall-stone seen as negative shadow in dyefilled gall-bladder. Operative confirmation.

Infections of the gall bladder can also take place through the lymphatics or through the portal circulation or by direct extension. We believe however, that the incidence of infection following either lymphatic invasion or direct extension is much less frequent than that caused by hematogenous infection.

We think this applies to ulcer of the stomach and duodenum as well, as they



Moderate sized opaque gall-stones.

are frequently found complicating cholecystitis.

We believe it to be of the utmost importance that medical care should eliminate every possible avenue of infection.

Roentgen study usually gives us valuable information in gall bladder disease; it should include several films of the gall bladder region, which may show gall stone shadows; a careful gastro-intestinal examination will, in the majority of instances eliminate the possibility of gastric or duodenal ulcer.

Radiographic examination of the gall-bladder after the method of Graham and Cole is essentially a test of the function of this organ. In addition the size, shape and position of the gall-bladder is determined and its power to expand and contract is seen. Emptying function is nicely demonstrated in normal cases after taking foods rich in fat. Non-opaque gall stones are sometimes shown as negative shadows in the otherwise opaque gall bladder and distortion of the organ by adhesions is occasionally seen. Differentiation of kidney stones from gall stones is also made possible. Sodium tetraiodophenolphthalein is administered either orally or intra-venously and after a sufficient time is concentrated in the gall bladder, rendering it opaque to the X-Ray.

Our method to date has been the oral one. After supper the night before the

Gall-bladder packed with many small faceted stones.

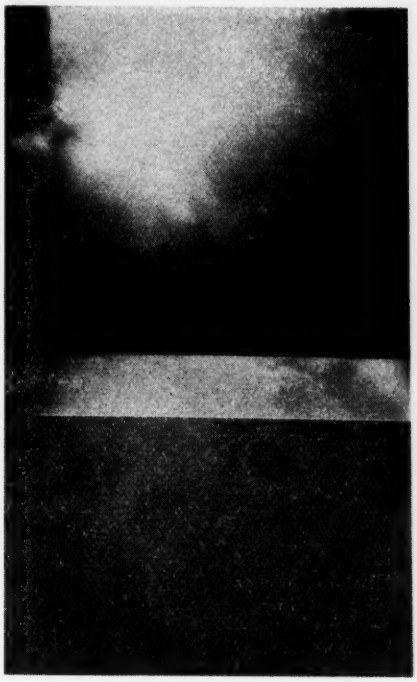
X-Ray is to be taken, the patient takes 5 grains of the dye for each 20 pounds of body weight, the 5 grain capsules are coated with salol or keratin to resist the acid of the stomach and dissolve readily in the alkaline reaction of the intestine. No food is taken after ingestion of the capsules and no breakfast is allowed in the morning. The first films are made at 9:30 a. m. and at 1 p. m. others are taken with the patient still fasting. This allows any change in density or size of the shadow to be observed. If no shadow is obtained or if the shadow is very faint, it is considered that the gall bladder is pathological, and the examination is complete. If

Gall-stones plus duodenal ulcer. Operative confirmation.

a good shadow is present, the patient is instructed to eat a glass of half milk and half cream, buttered toast and an egg. One and one-half hours after this meal another examination is made. If the gall-bladder is empty or very nearly empty it is considered to be normal. If the reduction in size is not marked, poor emptying function is demonstrated and the gall-bladder thought to be pathological. It is very important that a large film be taken in the morning to observe if the capsules have been well absorbed. In only six cases out of 227 have we found it necessary to repeat the examination on account of poor solution of the capsules. Reaction is not a disturbing factor, only 17 having vomited, practically in all of these after the capsules have reached the intestine, so as not to interfere with the test. Diarrohea occurred in about one-sixth of the cases. In 63 cases coming to operation our percentage of error has been approximately 10 per cent. We feel that with the further experience with the method this can be materially diminished. Recently Zink of St. Louis has reported no error in 65 cases coming to operation. He uses the intravenous method and his results would seem to indicate that this has a considerable advantage over the oral administration.

Occasionally single or multiple cholesterin stones may be present in the gall bladder and show little disease present. Another most important factor is that when the X-Ray is made, two or three weeks after a typical gall stone colic, the

findings will point toward a normal gall bladder, whereas an X-ray taken during or a few days after the attack of cholecystitis with or without gall stones would show disease of the organ. This does not lessen the value of this test, and it is highly important that surgical judgment be



Pathological gall-bladder. Note that the film on the right shows little reduction in size of gall-bladder 1½ hours after fat meal. Operative confirmation.

used with the X-Ray Department, and they should have the facts of the clinical history in order to carefully correlate their findings. The X-Ray department should be considered in consultation in all such problems and not just as mere technicians.

TREATMENT

Many of the serious complications of gall bladder disease are caused by delay in proper treatment. Patients are often not advised regarding the importance of early surgery, even after repeated attacks of biliary colic, at times associated with muscular rigidity, chills, fever and even empyema of the gall bladder.

Ninety-nine per cent of the mortality, and almost all of the morbidity follow complications. Carcinoma of the gall bladder is nearly always associated with gall stones of many years duration.

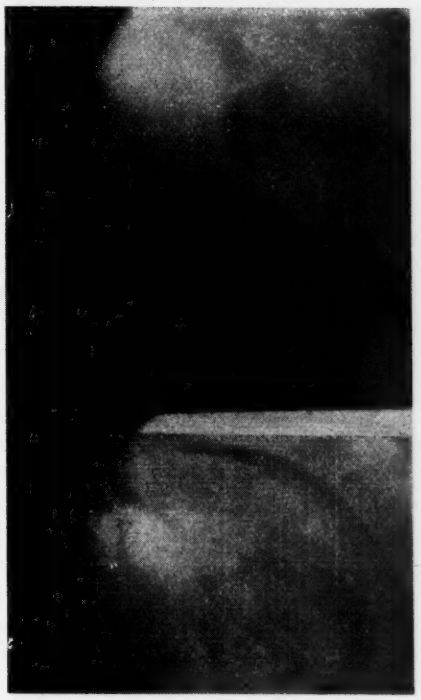
Many patients come to the operating room with severe degenerative heart and liver complications, that might have been avoided by early operation.

TYPE OF OPERATION

The surgeon of experience will usually not decided what type of operation is to be performed until he sees the extent of pathology at the operating table. It is of the utmost importance to know the essential details of the patient's history, especially regarding jaundice, loss of weight, urinary and blood findings, which should always include blood clotting time. The anesthetic and anesthetist should also be carefully chosen.

Operations upon the gall bladder as emergency should be avoided when possible by earlier diagnosis. Patients can often be brought from a serious condition to a very much improved condition by hours or a few days of judicious preoperative treatment.

This treatment would include a large amount of saline by hypodermoclysis, glucose and calcium chloride intravenously and digitalization in some cases. Digitalization is especially important in the long standing cases of cholecystitis in the obese. There are so many complications that may arise in gall bladder operations that they



Pathological gall-bladder. Note that film on right shows only slight reduction in size of gall-bladder 1½ hours after fat meal. Operative confirmation.

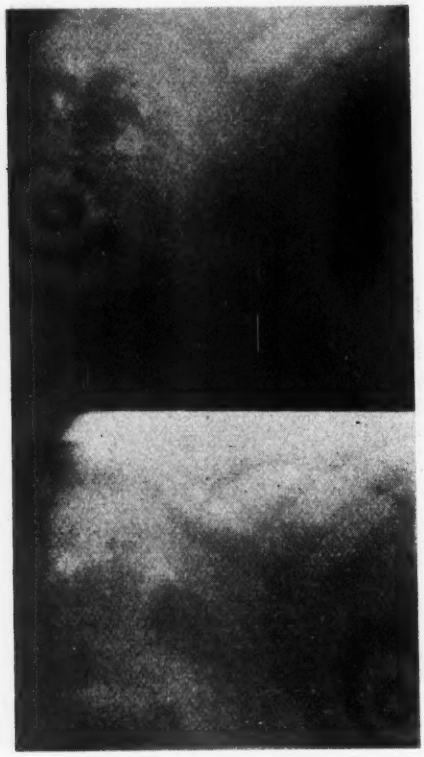
should not be performed except by the most experienced and trained surgeons, associated with well qualified assistants, as there are always factors during the operation, and in the post-operative treatment where this team work is most important.

The thought of the safety of the patient should be constant, and not doing some particular type of operation.

It is generally conceded that the operation of cholecystectomy is preferable to chelecystostomy in the larger series of cases, but both operations have their place, and there can be no hard and fast rule. The surgeon should decide at the time of the operation the proper type to be used.

At times the operation which can be performed the easiest for the patient will be the safest, on account of serious complications, such as jaundice or secondary to accompanying serious illness, such as typhoid fever, acute streptococcic infection of the throat or in general septicemia.

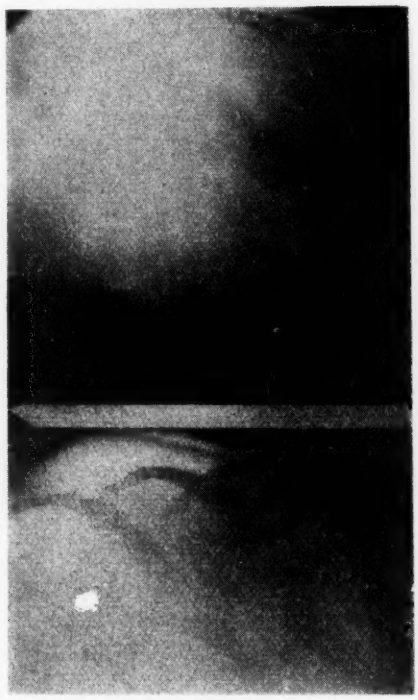
In some cases of empyema of the gall bladder accompanied by hepatitis, especially in the aged or obese, cholecystostomy is often the best method. In biliary cirrhosis cholecystostomy is the method of choice, and it is of especial importance that medical treatment should not be prolonged, as the liver will be greatly damaged by even what is considered a relatively short period of jaundice.



Pathological fiall bladder. Film on right shows no reduction in size of gall-bladder 1½ hours after fat meal. Operative confirmation.

It has been customary to treat all cases of jaundice by medical treatment, which sometimes is pro-longed and often unsatisfactory. A great deal of damage may be done to the liver by such treatment, and operation for drainage should not be omitted when the symptoms are not relieved in a short time.

Cholecystostomy is to be preferred when there is a question of hepatic or common



Normal gall-bladder. Note complete disappearance of shadow 1½ hours after ingestion of meal rich in fats. Operative confirmation.

duct obstruction, unless at the time of operation we have performed a choledochtotomy, as in the secondary operations for common duct or hepatic duct obstruction, the gall bladder is usually a good guide and may be utilized in cholecystogastrostomy or cholecystoduodenostomy. In cases of pancreatitis, whether moderate or severe, cholecystostomy is a preferable method, and in biliary cirrhosis it is the method of choice. There are other conditions where ostomy should be prefered, but time will not permit a detailed eneumeration.

Cholecystectomy is to be preferred rather than cholecystostomy in most cases primarily on account of the frequent recurrence of stones after cholecystostomy and secondarily the relief of symptoms is often of short duration after cholecystostomy, because the infection is usually not alone in the gall bladder cavity, but in the mucous membrance of the gall bladder and ducts; and thirdly cholecystectomy is to be preferred on account of the obstruction of the cystic duct whether from infection or stones, and fourthly, gangrenous gall

bladders should be ectomized, and in many cases a choledochtostomy should be performed at the same operation.

Removal of the gall bladder is indicated in contracted or non-functioning gall bladders, secondary to chronic cholecystitis. Patients are often seen by both the physician and surgeon where there is question regarding cancer of the bile ducts and pancreas, and they should be very careful in making a diagnosis, as many cases which are supposed to be cancer are cases of common duct stone accompanied by obstruction. In nearly all of these cases, there is a secondary pancreatitis, which may lead the physician to make a mistake in diagnosis. When time is available the VanDenBurg test for biliary function should be performed, and while it is not always reliable, it will become more and more valuable, by more frequent use, and patients should be given the benefit of any diagnostic aid which will help in his treatment.

THE VAN DEN BURG TEST—DIRECT AND INDIREST

(A) *Purpose*—To differentiate obstructive from hemolytic jaundice.

(B) *Principle*—Based on Erhlich's Diazo Reaction. Bilirubin when dissolved in chloroform or alcohol gives with diazonium salts, a reddish color in acid solutions. Normal serum contains bilirubin in dilutions of 1-400,000 to 1-250,000. No other substance will give the reaction.

(C) *Technic*—The blood is taken from the vein in the usual way, and allowed to clot. 3 c.c. blood serum, Erhlich's Diazo Reagent:—

(1) Sulphanilic Acid, 1 c.c.; Concentrated HCL, 15 c.c.; Distilled water, 1000 c.c.

(2) Sodium Nitrate, .05 gram; Distilled water, 1000 c.c.

Reagent is a mixture of (1) and (2):

25 c.c. of 1.; 0.75c. of 2.

Direct Test—1 c.c. of blood serum plus 0.25 c.c. of fresh Diazo regeant. May get any one of three positive reactions.

1. Immediate reaction begins at once and is maximal in 10 to 30 seconds, bluish-violet color with intensity depending upon amount of bilirubin present.

2. Delayed Reaction. I to 15 minutes giving a violet-red color.

3. Bi-Phasic Reaction. Reddish at once becoming violet in 10 to 30 seconds.

Indirect Test—(1) 1 c.c. of serum. (2) 2 c.c. 96 per cent alcohol. (3) Centrifuge until clear yellow supernatant fluid is obtained. (4) 1 c.c. supernatant fluid. (5) 0.25 c.c. Erhlich's Diazo reagent.

If positive gives a violet-red color of maximal intensity at once.

(D) *Interpretation*—

1. If reaction is immediate or direct, i.e., if direct is positive it means an Obstructive Jaundice.

2. If Indirect is positive then the Jaundice can be inferred to be: (a) Hemolytic or, (b) dependent upon some functional derangement of liver cells without obstruction.

Serums that give a positive Direct will also give a positive Indirect, but the converse is not true.

By this simple test a destinction can be drawn btween icterus due to obstruction of the main bile ducts from gall-stones, tumors, hepatic dirrhosis and icterus of hemolytic, infective or functional origin.

One seldom sees cases of malignancy of the ducts or pancreas in which the loss of weight and anorexia is not rapid and progressive.

In operations upon patients in which cancer of the pancreas or gall bladder, is found at the time of operation, the patient is usually more comfortable if the wound is closed and no operation is performed excepting what has been necessary to make an exact diagnosis by exploratory incision. It is of the utmost importance that the surgeon must view the subject of biliary surgery with broad vision. There should be no conflict between cholecystostomy and cholecystectomy, the most important factor is to know the vital resistance of the patient, and then consider the correct surgical proceedure for the case at hand with these complications.

Mortality after operation in cases in which the diagnosis is correct and the treatment not neglected, is so small that it need not be considered. Morbidity of these cases will be in direct ratio as to the length of time and the character of the infection, and the complications before the proper proceedure is instituted. It is often important to do the gall bladder operation upon a patient upon whom it is planned to perform another operation at the same time, like myomectomy or hysterectomy. After a carefully taken history, and a probable diagnosis of associated gall bladder disease made, it is important that instruments and assistants be prepared so that the gall bladder operation can be performed after the pelvic operation, provided the patient's condition is satisfactory.

It is well to wait until the first operation has been finished and the inventory of the patient's condition and resistance carefully considered, before deciding to do the gall bladder operation. Routinely we advise examination of the gall bladder prior to any operation on the pelvic organs excepting those performed for acute conditions, in which any further operation than the primary one is not to be considered.

It is by making these preliminary examinations that we determine first the presence of gall stones or cholecystitis, and the need of this operation so that prepara-

tions may be made for such while proceeding with planned pelvic operation.

We have always considered removal of the appendix routinely a safe and sound surgical proceedure when the patient's condition is satisfactory and other pathology does not contra-indicate such. In the obese or aged, in patients not in vary good condition it is not advisable, as a rule to perform a gall bladder operation at the same sitting as another operation in the pelvis. In young people or those in good condition, both operations can be performed with safety, witn very little additional risk. In these cases from the preliminary examination and palpation one knows whether the gall bladder operation will be difficult or not depending upon adhesions, manner of taking anesthetic, and other conditions at the time. The gall bladder operation takes only a few minutes when preparations have been made before hand. We have routinely performed this as above in a large number of cases, with no mortality.

One should never advise double operation, unless conditions for post-operative care are ideal. It is of importance that the proper instruments, retractors, etc., are available in gall bladder surgery. The anesthetic and incision are of the utmost importance, one cannot expect to perform a satisfactory operation through an unsatisfactory incision. Good exposure goes hand in hand with good surgery.

In impacted stone in the cystic or common duct, we have found it extremely satisfactory to bisect (show photo here), the gall bladder into and through the cystic duct.

We usually prefer to explore the common duct before removal of the gall bladder if such is planned as the method of proceedure, as it is only after making the common duct examination that we can determine whether or not the gall bladder should be removed. At times with low obstruction of the common duct, a transduodenal incision should be used, combined at times with incision in some portion of the common duct. The incisions in the common duct and duodenum should always be closed with every fine chronic catgut sutures threaded on a fine needle. Great care should be used in opening the common duct, a clean cut incision should be made to avoid unnecessary trauma. If a tube is placed in the common duct it should be small, not over one-half the size of the common duct. A "T" tube is often best, one arm extending toward the liver, and one toward the duodenum. Fine sutures like 00 should be used in suturing the common duct, as the tube will usually be ready to be removed at the time the sutures are absorbed.

In long standing obstruction of the common duct, the bile should not be allowed to escape too freely through the tube as dehydration, on account of the sudden relief of back pressure in common duct will occur. The tube should be clamped off, and only used as a safety valve, allowing the bile to escape through the duct into the duodenum where it belongs. At times this tube can be used to introduce fluids into the duodenum where it belongs. At times this tube can be used to introduce fluids into the duodenum, saline or glucose, and it is often better instead of instituting external drainage to introduce a small tube after the method of Sullivan into the common duct and allow it to remain there. This will often be the case when there has been a previous operation with perhaps an injury to the common duct at the time. This small tube can be very satisfactorily used, also in the operation choleystenterostomy and cholecystogastrostomy.

DRAINAGE

Some surgeons perform as a matter of routine, cholecystectomy and operations on the ducts without drainage. We have felt that it was somewhat safer in most cases to institute drainage. We believe however, that this should not be a drainage tube or gauze, or a combination of either, but best a small strip of rubber tissue. This soft rubber tissue is not as likely to cause adhesions or fistulae.

A post-operative drain into the Morrison's pouch through a stab incision as advocated by Crile, and is probably the best method of drainage. It very much lessens the danger of post-operative hernia, which is a considerable danger, especially in the obese. When a drainage is used, it is usually not disturbed for seven or eight days.

Our records show that there is biliary drainage to some degree, after our cholecystectomies, in one case in thirty. We think that there is much less biliary drainage after cholecystectomy if clamps are not used on the cystic duct, and tied with heavy cat-gut sutures. Small suture material should be used like No. 0 or No. 1 with fine needles. This operation presupposed, of course, that cholecystectomy is performed from the duct upwards, which is usually our method of choice. We have

come to consider that operation through the gall bladder biliary tract is one of the safest in surgery, provided that the patient is in fair condition at the time of operation. It cannot be expected that good results will be obtained in moribund cases. Even if they do not die on account of the delay, the morbidity and complications secondary to hepatitis, cholangitis and pancreatitis are often serious and permanent.

We urge therefore, that after a diagnosis has been made of cholecystitis, with or without stones, that only a reasonable time should be allowed before surgical intervention. In some cases a few days or weeks might be a reasonable time, in others that are serious or associated with vomiting, chills or fever, medical treatment may be advisable for a longer period of time. We question very much whether the gall bladder functions normally after a well marked attack or following a number of lesser attacks of cholecystitis.

POST-OPERATIVE TREATMENT

Cases that have been seriously ill for a few days can often be improved by saline solution immediately before the operation, and on the operating table. In cases associated with jaundice, one or two blood transfusions, with small amounts of from 100 to 200 c.c., one given the last 24 hours before the operation will be of great benefit to the patient. In serious and jaundiced cases, immediately after the operation, patient should have a blood transfusion, if possible from the same donor, as he had before the operation. Saline should be given by hypodermoclysis or intravenously. The rectal method is unreliable for such patients. The intravenous method should be continued with or without glucose solution for a period of many days after the operation. The head of the bed is usually raised six or eight inches, and the patient is usually allowed to have two or three pillows. This gives him an extreme amount of comfort, which can never be obtained by lying flat in bed. A pillow under the knees and one at the feet will also aid him to use his abdominal muscles and favors peristalsis.

Patient is kept warm at the time of the operation with hot water bags or electric pads over the liver and back, and over the abdomen and thighs. Often a combined local anesthetic with gas will be the most satisfactory. Spinal anesthesia, combined with block over the area of incision or ether also have their proper places.

TYPE OF OPERATION

	Acute Cases	Chronic Cases
Cholecystectomy with soft rubber drain down to site of operation	2	243
Cholecystectomy with drainage of cystic duct	73	147
Partial Cholecystectomy with drainage of cystic duct	29	18
Cholecystostomy	71	96
Choledochotomy and removal of stones from common or hepatic ducts	0	8
Choleduodenostomy	0	1

MORTALITY IN ACUTE CASES.....5.1%

4 cases with acute hemorrhagic pancreatitis.
4 cases with acute gangrenous cholecystitis.
1 case of empyema of gall bladder with cardiac embolus.

MORTALITY IN CHRONIC CASES.....1.7%

4 cases with severe jaundice.
1 case with intestinal obstruction.
1 case with bile peritonitis.
1 case with pneumonia.
2 cases with peritonitis and septicaemia.

RESUME OF 688 CASES OF BILIARY DISEASE OPERATED ON DURING THE LAST 8 YEARS

Male patients	176
Female patients	512
Youngest patient	19
Oldest patient	86
Average age	39
Average duration of symptoms	4½ yrs.
Average days in hospital	15 days

ACUTE CASES 175—INCLUDING

Empyemas	115
Gangrenous cases	58
Perforated cases	8
Cases with local peritonitis, cholangitis and pancreatitis	137
Cases with acute hemorrhagic pancreatitis	5
Cases with jaundice at time of operation	28
Cases with stones	164
Cases without stones	11

CHRONIC CASES 513—INCLUDING

Cases with stones	354
Chronic infected or strawberry type	159
Cases with cirrhosis	16
Cases with septa	12
Cases with jaundice at time of operation	15
Cases with stones in common or hepatic ducts	8
Cases of carcinoma of gall bladder	2

GANGRENOUS APPENDIX IN FEMORAL HERNIA

JAMES A. MacMILLAN, M. D.
F. B. MacMILLAN, M. D.
DETROIT, MICHIGAN

An interesting case of strangulated hernia came under our observation. Patient gave a history of a lump in the right femoral region for the past 22 years which would appear with any straining of the abdominal muscles. This at first was very small but for past three years had become larger. It gave no trouble and would often disappear. One week previous to our call the patient was taken with sudden pain over lump which would not disappear. When home remedies failed for eight days, the doctor was called. Patient stated the above history and added that she had felt nauseated, though had not vomited during the pase week. Her bowel movements had been exceedingly sluggish. The pain was sharp and steady in character.

Examination—Female patient, aged 54 years. Apparently acutely ill. Chest and abdomen were normal. Examination of femoral region of right side disclosed a lump the size of an egg which was reddened and painful to touch. This could not be reduced by palpation or manipulation. Diagnosis of strangulated femoral hernia was made and operation was advised. A Bassini incision was made and the sac exposed. This contained several clear cysts within its walls; was single, and dark in color. The contents were examined and found to be the vermiform appendix, gangrenous, and tightly constricted 3½ inches from the proximal end by the femoral ring. This was freed by enlargement of the ring. Appendectomy was performed by drawing the appendix downward to expose the base. Closure was completed in the usual manner.

Strangulated femoral hernia of the vermiform appendix is a rare condition. Watson collected 512 cases of hernia of the appendix. Of these, 269 were inguinal, 217 femoral and 2 obturator. In 24, the site of the hernia was not stated. Thus, about 42 per cent of appendiceal hernia are femoral in type. Because the femoral ring is not as constant, nor as large as the inguinal ring, femoral hernia of the appendix is less frequent than inguinal hernia of the appendix.

REFERENCES

Leigh Watson: "Hernia," p. 529.

Foster Smith: Ilium, caecum, appendix, strangulated in left hernia. British Med. Jour. March 20th, 1926.

A. J. Price: Appendix in right inguinal hernia sac. British Med. Jour. Feb. 27th, 1926.

A CASE OF CORYMBRIFORM SYPHILID TWO OR THREE WEEKS AFTER THE INITIAL LESION

Cyril K. Valde, M. D.

DETROIT, MICHIGAN

The following case is presented because of the comparative rarity of the corymbriform syphilid, appearing so soon after the initial lesion and accompanied by slight pruritus:

The patient, C. L., a Negro, aged 29, came into the Dermatological Clinic, Buhl Memorial, Harper Hospital, January 17, 1927. He had had a penile chancre five or six weeks previously. He presented a generalized eruption of one month's duration, together with headaches and general malaise.

In the left coronal sulcus of the penis there was a scar marking the site of a recent ulceration, probably the initial lesion. On the forehead and chin there was an eruption of large brownish-red infiltrated papules, with superficial excoriations about both alar nasi. On the upper lip were four fairly large nodules. A generalized small papular eruption was present, and especially on the trunk the lesions were follicular and grouped in coin-sized patches (corymbriform arrangement). The lesions on the thighs, arms, and forearms were mainly large papules, with faint scaling; some were follicular. The palms and soles were not involved. There were a few papules on the shaft of the penis, but no moist papules on the scrotum or in the perineum. (See photographs). On the right anterior faucial pillar there were two or three mucous patches. All of the groups of superficial lymph nodes were palpable, especially the inguinal.

The Wassermann reaction of the blood was strongly positive.

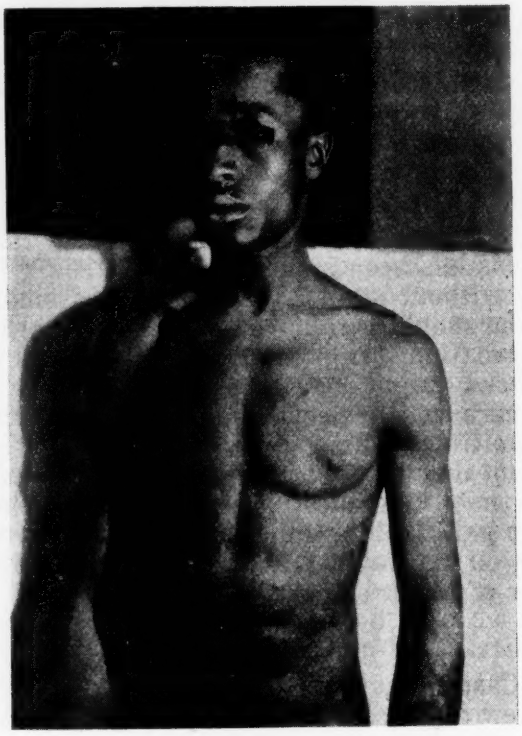


Photo by Russlander.

C. L., Negro, aged 29—This photograph shows faintly the lesions on forehead and chin, nodules on upper lip and front view of generalized papulo follicular eruption.

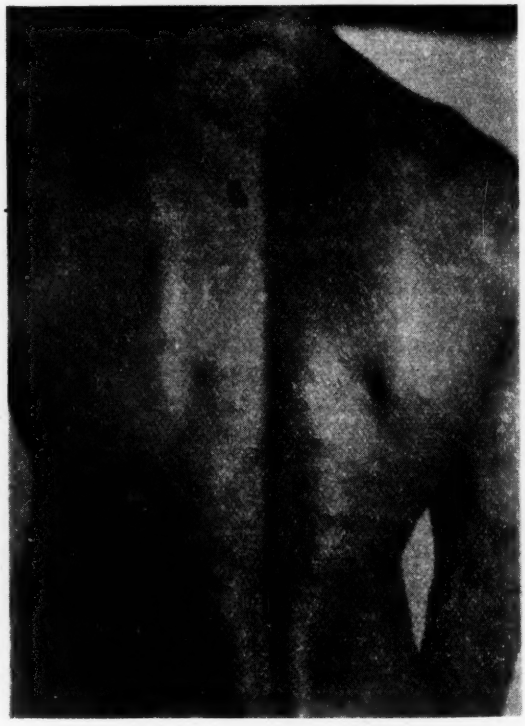


Photo by Russlander.

C. L., Negro, aged 29—This photograph shows the follicular lesions and grouped coin sized papules (corymbriform arrangement).

MICHIGAN'S DEPARTMENT OF HEALTH

GUY L. KIEFER, M. D., *Commissioner* · *Edited by* MARJORIE DELAVAN

SMALLPOX

The smallpox situation in the state, while not alarming, is a matter of no little concern. During October, November and December 1925 there were 106 cases reported while during this period in 1926 there were 205 cases. For the fiirst 29 days in January 93 cases were reported in 1925, while in 1926 the number has jumped to 164.

At the present time smallpox is prevalent in several counties. Mason County reported 42 cases during January, Oceana 12, Lapeer 28, Genesee 25, Van Buren 20, and Isabella 4. In Mason County most of the cases occurred in the city of Ludington. Five cases have been reported from Berrien, 3 from Kalamazoo, 3 from Dickinson, and 1 from Marquette, while Calhoun, Oakland, Tuscola, Midland, Allegan, Muskegon and Antrim reported one case each in January.

The cases are with few exceptions of a very mild form, a type difficult to control from the public health standpoint since many of them are diagnosed chickenpox or are entirely unrecognized.

In each instance in the counties where the disease is at present prevalent the first cases were diagnosed chickenpox and were not quarantined. In this way the infection was spread throughout the community before the real nature of the condition was recognized. In many instances the symptoms have been so mild that a physician has not been called. Investigation in one community revealed the fact that this mild type of smallpox had been present in one school district for about two months during which time it had been called chickenpox and in no instance had a physician been called.

The early symptoms of headache, backache and nausea have frequently been diagnosed "flu" or LaGrippe by the attending physician at his first and only visit. With the relief of symptoms at the time of the occurrence of the eruption a few days later the patient has gone back to school or to work spreading the infection whereever he went.

The following points are important aids in the diagnosis of smallpox:

The absence of any history of having had smallpox or a successful vaccination within the past five years.

The occurrence of the eruption in one crop only, all lesions having the same appearance at any given time. There may be not more than 5 or 10 pustules over the entire body or the body may be covered with the eruption, yet the lesions do not show the various stages at one time as seen in chickenpox.

The pustules develop more plentifully on the face and extremieies than on the body, as in chickenpox.

The lesions of chickenpox are quite superficial and are easily broken while in smallpox they are deeper and feel firm and resemble split shot in the skin.

The early diagnosis and strict quarantine of these cases as well as the widespread use of vaccination are most effective measures in the control of this disease.

Successful vaccination within a period of five years definitely protects an individual against smallpox and it is only because of failure or refusal to be vaccinated that this loathsome disease is allowed to spread. In a state like Massachusetts where vaccination is compulsory, smallpox is rarely ever seen.

The following letter has just recently been sent out to all physicians and health officers of the state:

"Smallpox in a mild type is somewhat prevalent, being widely scattered throughout Michigan at the present time. The reason the disease is gaining a foothold is because these mild cases are frequently diagnosed as chickenpox or even cuban itch and are not quarantined.

The time to prevent an epidemic is before it starts. It is well for us to remember that the mild type of smallpox has frequently been found at the beginning of an epidemic which later developed into an outbreak of malignant smallpox.

This is the time to urge people to become vaccinated and revaccinated. Let us see to it that everyone in our communities who has not been successfully vaccinated within five years becomes vaccinated at this time; also let us be careful in our diagnosis of any case resembling smallpox and see to it that the mild cases are reported and quarantined.

There is no reason why we should have a repetition of some of the epidemics that we have seen in Michigan in the past and with the co-

operation of the physicians and health officers this cannot happen."

Very truly yours,

Guy L. Kiefer, M. D.,

Commissioner, Collaborating Epidemiologist, U. S. Public Health Service.

VIOLENT DEATHS IN MICHIGAN IN 1926

Violence of all forms has always been an important factor in the death rate but since the advent of the automobile it is becoming increasingly so. In 1926 the automobile was by far the most important cause of violent deaths, there being 1,177 deaths assigned to this cause, including other accidents in which the automobile was a factor such as a collision with a railroad train or street car. This is an increase of almost 10 per cent over the preceeding year.

To have a cause assume such enormous propositions in 15 years is a sad commentary on our civilization. We are putting automobiles, which are as dangerous as 155 mm. guns, in the hands of reckless and careless individuals some of whom are really morons, and letting them go on their death-dealing way without interruption. No law or traffic regulation is going to make a careful driver of a reckless fool.

The next most important cause in the group is accidental falls. In 1926 there were 633 deaths from this cause as compared to 602 in 1925. This is only about half the number of deaths due to automobiles.

Third in the group comes suicides of which there were 565 as compared to 495 in 1925.

Then fourth in the list is homicides. There were 446 persons murdered in Michigan in 1926, an increase of more than a third over 1925 when there were 313.

It will be noticed that all these important causes showed an increase over the preceeding year.

The next item, drowning was more satisfactory. There were 294 deaths from this cause as compared with 324 during 1925.

Sixth on the list comes burns of which there were 245 as compared with 230 in 1925. These are burns and scalds but do not include conflagrations.

Relatively few years ago railroad accidents were the most important of the causes of violent deaths. The very excellent work that is being done by the railroad companies has reduced this from first to seventh place. There were 183 deaths reported in 1926 as compared to 180 reported in 1925. It is believed that this factor can be further reduced and it is hoped that railroads will continue to extend the good work already accomplished. This figure does not include the deaths due to collision of automobile with train which are included in the automobile deaths.

The next important causes of death are the two items of suffocation and absorption of gases which caused a loss of 147 lives in 1926 as compared with 112 in 1925. It will be observed, however, that this item does not include suicide by gas, these being counted under suicide deaths.

Food poisoning and other acute accidental poisonings were responsible for 106 deaths as compared with 94 in 1925.

Conflagrations, that is, burning buildings, were responsible for 94 deaths, more than double the figures for 1925 when there were only 43 deaths.

The next item showed an enormous increase for deaths in mines and quarries. There were 93 deaths assigned to this cause as compared with 39 in 1925. This item includes the 51 deaths that were caused in Ishpeming by the flooding of a mine. Omitting this item it will be found that the figures were only slightly in excess of the 1925 figures. Catastrophies of this kind, of course, make an enormous difference in the rate when they do occur.

The next important item is that of street car accidents which took the lives of 92 Michigan during 1926. This is compared with 67 in 1925.

Traumatism by machinery follows next with 89 deaths. This is a reduction of 3 from the figures of 1925 when there were 92 deaths from this cause.

Accidents with firearms caused 74 deaths in 1926 as compared with 75 in the preceeding year.

The next item which covers other vehicles and other crushings has 65 deaths as compared with 118 in 1925. These were divided as follows: Motorcycles, 9; Aeroplanes, 6; other vehicles, 20; Landslides and other crushing, 30.

Electricity caused 50 deaths in 1926 as compared with 51 in 1925. This does not include lightning.

Injury by animals for the next item caused 33 deaths as compared with 39 in 1925.

It is evident that the summer was not as hot as the preceding year as there were only 25 deaths due to heat prostration as compared with 53 during the preceeding year.

Twenty persons were frozen to death or died as a result of exposure during 1926.

This was exactly the same number as died from this cause in 1925.

The next item on the list is that of lightning. Six persons were struck by lightning in 1926 as compared with 10 in 1925.

As stated above, violence is becoming a more and more important factor in our death rate and this little review does not include a large number of deaths in which the causem of death was stated as "fracture" but the cause of the fracture was not stated, and consequently it was necessary to assign these to the indefinite violence list.

SCARLET FEVER

As evidence by correspondence received by the Michigan Department of Health from physicians throughout the State, a subject of timely interest is that of scarlet fever prophylaxis and therapeutics.

The Biologic Products Division of the Department of Health is now prepared to distribute Dick toxin for skin testing and scarlet fever streptococcus toxin for active immunization. When a physician or health officer wishes to immunize a group, he should notify the Department of Health how many he wishes to immunize. Dick toxin will then be sent to him for testing the number of susceptibles in the group. The first dose of scarlet fever streptococcus toxin will then be forwarded for immunizing the susceptibles. Ten days later the second dose will be forwarded, and ten days later the third.

To illustrate the procedure followed and also the results which may be expected the Michigan Department of Health Dick toxin and scarlet fever streptococcus toxin there is given below a series of extracts from correspondence with G. E. Frank, M. D., health officer of Harbor Springs, Mich.

Dr. Frank writes, "I received the consignment of scarlet fever serum last evening. I will now need the same amount of the 5000 unit strength for the second injection which I wish to receive about January 3 and toxin oı the 30000 unit strength about January 18. We are very grateful to you for the prompt care you have given us in our epidemic."

After the third dose had been given, the Michigan Department of Health wrote to Dr. Frank: "Do you anticipate using the Dick test on the people you have immunized wit hscarlet fever streptococcus toxin? We would be pleased to have you write, giving your experience in the use of this product, also advise how many children you have treated with the first, second and third doses of scarlet fever toxin. We are having a misunderstanding among physicians. Many of them are attempting to use scarlet fever anti-toxin in place of scarlet fever toxin and vice versa which necessarily is forcing us to put restrictions on the distribution of this product."

Dr. Frank made the following answers to the above questions. "I anticipate using the Dick test on children who have been immunized the past few weeks but not before school closes in the spring as I feel that a test given too soon after the injections is not of much value. I gave the first dose to 318, the second to 316 and the third to 256. This is the first general immunization ever attempted in this town and I feel that we have had a wonderful response from the people. I had been educating them toward this end for some time. I had a few rashes of a day's duration after the first dose. After the second there was a fair number tnat was quite sick and showed a marked picture of anaphylactic phenomena. This did not surprise me after my experience with other serums, but made a pronounced impression on some of the children and parents and was the cause of the decrease in the number taking the third injection. Now, almost daily, however, there are some persons coming to have the third dose, after changing their minds about it, since among the children who took the third injection there was scarcely one who had a reaction to speak about."

Our reply to Dr. Frank is given in conclusion. "You will find that immunity is acquired rather more rapidly with scarlet fever toxin than with diphtheria toxin-antitoxin mixture, so that if you wish to reDick in 30 days you may do so. We only suggest this so that you may keep it before your people."

PRENATAL PROGRAMS

A demonstration prenatal program was started in Emmet County January 1, under supervision of the local physicians. Katharine Kreizenbeck, R. N., of the staff of the Bureau of Child Hygiene and Public Health Nursing, has charge of the work and during January she called on 44 new prenatal cases with the consent of the attending physicians and made 174 other visits in connection with the program.

Osceola County has a similar prenatal program already in operation, under Bertha Karkau, R. N. Miss Karkau reported 11 new prenatal cases during December and 22 in January. She also made 319 calls during that time, 47 of them on the physicians supervising the program.

DIPHTHERIA PROTECTION

The diphtheria protection unit of the department worked in Cass and Kent counties during December and January. In 15 clinics in Cass County 1,062 persons were Schick tested, completing the Cass County schedule, and in 36 clinics held thus far in Kent County 3,241 persons have been given the test. Results are read a week after the test is given.

TEACHING INFANT CARE IN SCHOOLS

Saginaw County's reception of the series of Little Mothers' League Classes conducted by Martha Giltner, R. N., of the staff of the Bureau of Child Hygiene and Public Health Nursing, is well set forth in an article in a Saginaw daily paper.

"One of the most popular courses in the county's rural schools is that offered by the State Health Department in the care of children through the organization of Little Mothers' Leagues for girls between 11 and 16 years of age. More than 600 girls are enrolled in the work, in the 20 schools where leagues have been organized.

The work deals entirely with the care, proper feeding, dressing, required sleep needed and all the things necessary to know to bring up healthy children. The classes are being instructed by Miss Martha Giltner, of the State Health Department, who spends one hour a day each week at the 20 schools.

"I have never been so enthusiastically received as I have been in Saginaw county" Miss Giltner stated Monday, "and many of the parents have expressed their appreciation to me for the things they have learned through their children in the care of infants."

Miss Giltner told of a home where a child had been sickly and a girl taking the course volunteered her services in helping care for the baby.

The Little Mothers' Leagues were organized in the fall by Miss Esther Nash of the State Health Department and Miss Mabel L. Morgan, county school nurse. The department then sent Miss Giltner to give the course that is of 10 weeks duration, and is given free of charge. School credit is given to all girls taking the work. The leagues are part of a statewide program of the State Health Department.

In Kalamazoo County, Gertrude Linsell, R. N., has an enrollment of 422 girls in Little Mothers' Leagues in 12 schools.

Montcalm County has ten schools giving Little Mothers' League work under Catherine Eoll, R. N., with an enrollment of 713 girls.

Annette Fox, R. N., in St. Joseph County, has 394 girls in 9 schools, and Bertha Cooper, R. N., in Barry County has an enrollment of 462 in 9 schools.

St. Clair County has just begun Little Mothers' League work under Nella Hummer, R. N.

The demand for instructors for Little Mothers' League classes has far exceeded the number available on the department staff, and many communities have been disappointed.

PREVALENCE OF DISEASE

January Report
Cases Reported

	December 1926	January 1927	January 1926	Av 5 years
Pneumonia	523	661	864	795
Tuberculosis	297	647	329	352
Typhoid Fever	24	26	39	49
Diphtheria	592	499	403	760
Whooping Cough	502	560	1,030	566
Scarlet Fever	1,224	1,438	1,453	1,440
Measles	413	523	4,837	1,840
Meningitis	7	10	7	16
Poliomyelitis	5	8	1	3
Syphilis	1,058	1,083	1,288	919
Gonorrhea	772	713	725	808
Chancroid	3	7	10	14

CONDENSED MONTHLY REPORT

Lansing Laboratory, Michigan Department of Health
January, 1927

	+	—	+—	Total
Throat Swabs for Diphtheria				1088
Diagnosis	26	359		
Release	112	207		
Carrier	17	337		
Virulence Tests	12	8		
Throat Swabs for Hemolytic Streptococci				644
Diagnosis	109	203		
Carrier	43	309		
Throat Swabs for Vincent's	17	379		396
Syphilis				5070
Wassermann		1		
Kahn	786	4207	74	
Darkfield		2		
Examination for Gonococci	132	1146		1278
B. Tuberculosis				354
Sputum	60	259		
Animal Inoculations	2	33		
Typhoid				88
Feces	8	37		
Blood Cultures	1	16		
Widal	7	15		
Urine	1	3		
Dysintery				31
Intestinal Parasites				30
Transudates and Exudates				274
Blood Examinations (not classified)				743
Urine Examinations (not classified)				333
Water and Sewage Examinations				399
Milk Examinations				105
Toxicological Examinations				5
Autogenous Vaccines				7
Supplementary Examinations				216
Unclassified Examinations				641
Total for the Month				11722
Cumulative Total (fiscal year)				90957
Decrease over this month last year				4349
Outfits Mailed Out				12866
Media Manufactured, cc. (Includes 68,360 cc. special media)				195960
Typhoid Vaccine Distributed, c.c.				1150
Toxin Antitoxin Distributed, c.c.				28470
Diphtheria Antitoxin Distributed, units				39932000
Silver Nitrate Ampules Distributed				5980
Examinations Made by Houghton Laboratory				1467
Examinations Made by Grand Rapids Laboratory				5101

EDITORIAL DEPARTMENT

EDITOR: Frederick C. Warnshuis, M. D., F. A. C. S.

ADDRESS ALL COMMUNICATIONS TO THE EDITOR—1508 G. R. NAT'L BANK BLDG., GRAND RAPIDS, MICH.

IDEALS AND CO-OPERATION

EDITOR'S NOTE: The following is the address made by President Jackson at the Council's Conference Dinner, held in Ann Arbor, January 24th. It indicates anew your Society's ideals and activities.

It is fitting on an occasion like this that one should speak briefly of some of the ideals of our State Medical Society, especially as these ideals may be related to the other organizations represented here tonight. After several years of more or less active interest in state medical organization one is privileged to form some conclusions as to what our society should have before it as its objectives.

It seems to me that as an organization we should be looked to for leadership in all things that may be instrumental in bringing about preservation of health and improvement in the case of the sick. It is our job to bring about co-operation of all agencies which are striving for these ends.

The public health work carried on by the state through its council and the commission of health is a matter of vital interest to the State Medical organization. So, too, is the work of all public health officials. Public health work is the child of organized medicine. It is due to our efforts that the great value of such work has been recognized by all progressive states and municipalities. There has been some tendency in these later years for criticism, on the part of the profession, of public health officials because of the fear of the bringing in of state medicine. Health officers have criticized doctors for failure to co-operate with them. It seems that many of these causes of friction might be done away with if we could get together and talk things over before hand. In my opinion there is no real reason why organized medicine and public health officials should have any real trouble. We are all interested in the same object, the prevention of disease and the proper care of the sick. I submit that as a class, doctors are more interested and more altruistically interested in this than any other body of citizens. It seems reasonable for public health officials and organized medicine to really co-operate in what they do rather than to each to proceed independently and then indulge in indiscriminate and foolish criticism of each other. As president of our State Society I wish at this time to assure our commissioner of health that we stand ready to co-operate with him in his efforts to give the State of Michigan the very best possible in public health administration. Our Journal has already given over a section of each issue for the purpose of keeping members of our profession aware of what is going on in the state department of health. Our Council and its executive committee desires the privilege of giving its influence and co-operation in bringing about the very best things in public health activities.

The state board of registration is organized to protect those who call upon men engaged in the healing art to care for them when they are sick. Members of this board are chosen from the ranks of the members of our State Society. They thus represent our State Society in carrying out a particular work which is one of the objectives of organized medicine. Since such is the case it is manifestly the plain duty of the State Society to offer to this board every possible assistance in making its work efficient. Whatever influence we may have should be put solidly behind the efforts of this board in its efforts to eliminate incompetence and quackery in the care of the sick. We should be glad to have the Board of Registration feel that they do represent organized medicine in their work and that they should look to us, not only for support but for council and suggestion. The work of the board has been somewhat hindered by a lack of sufficient funds to do the most that is possible. There should be a full time executive secretary of this board paid an adequate salary. It has seemed to some of us that the work of this board should not be confined to merely licensing to practice but should be extended to investigating and prosecuting those who are practicing without license and proper qualifications.

It also sometimes occurs that those to whom license has been given in the course of a few years demonstrate that they are quite unfit to care for the sick. Those who are guilty of gross malpractice should have their license revoked. To thus extend its work the board must have proper financial support.

Our State Society is most intensely interested in the work of Medical Education. The future of our profession depends upon the character and training of the men turned out each year from our medical schools. Every clean, intelligent, well educated young doctor added to the profession makes it easier for the rest of us to live up to our ideals of medical practice. We need such recruits with which to carry on. Every poorly educated, unprincipled doctor turned out to practice in our state makes the practice of medicine more difficult and more unsatisfactory. Such men discredit us with the public. Who then should be more interested in the proper selection and training of the undergraduate in medicine, than those already engaged in medical practice. The A. M. A. has done much for the advancement of medical education in the United States. The Michigan State Medical Society as a component member of the A. M. A. is interested in medical education and particularly with that conducted within our state. We welcome any opportunity to be of service in carrying on this work. The Dean of the University Medical School has recently proposed a plan of preceptorship during the summer months. I am quite sure that if the plan is worked out, the members of our Society will be only too glad to do their part. To me, the plan seems to have a two-fold advantage—the student will learn about the practice of medicine and the doctor will learn something about the University. To me both the objects seem desirable.

We are also much interested in the securing of opportunities for Post-Graduate work in our Great University Hospital. It seems to me that in post-graduate instruction, the State Medical Society and the University Medical School are particularly drawn together. The improvement of the standards of medical practice is the ideal for which both organizations are existing.

The profession in Michigan is equally interested with the University in developing here, not only an increasingly fine under-graduate school of medicine and an effective Post-Graduate School, but also departments of research which shall make it possible for Michigan to have some appropriate part in the development of medical science. The vision which President Little gave us in October, of the possibilities along this line, is a glorious vision. The Michigan State Medical Society pledges its support in doing everything within its power in helping to bring about the realization of this plan.

The location of our new State Tuberculosis Sanitarium in Ann Arbor should be an opportunity for some real research work in tuberculosis. It seems that there is a real need for such research. There can be no doubt that there is a real need for more undergraduate and post-graduate instruction in what is already known about tuberculosis.

We have learned that an effort is being made to repeal the bill that makes possible the building of this building here at Ann Arbor. The State Society will do everything in its power to defeat this repeal.

In conclusion, let me say that my purpose in this brief talk is to express some of our ideals in medical organization, especially as these ideals are related to the work of the other organizations represented here today. We have already quarreled about some of these matters. This never would have occurred had these matters not been matters of *mutual* interest. Since they are matters of *mutual* interest, it is much better to work things out together. We shall not always agree about methods, but so long as we are working together for the same ideals, there can be no serious differences.

USE OF HIGH FORCEPS IN OBSTETRIC CASES

1. High forceps should never be applied unless their use is concurred in by competent consultation.

2. Forceps should not be applied in median or deep transverse arrest until sufficient time has elapsed for proper molding of the head to have taken place usually one and one-half to two hours, providing there are firm uterine contractions.

3. When the head is on the perineum, a period of one to two hours should elapse before the application of forceps is made. The fetal heart rate must be watched and in case of marked increase, or an unusual slowing, the application of low forceps should be considered. If retardation is due to a rigid perineum in the absence of uterine inertia, episiotomy should take precedence over the application of forceps.

4. In persistent occiput posterior posi-

tions where the uterine contractions are becoming weak with no evidence of spontaneous rotation and the head is firmly engaged, forceps should be applied according to Scanzoni maneuver.

5. In breech deliveries where there is difficulty in delivering the aftercoming head forceps should be used in preference to unrestricted traction on the neck, after the Smellie-Veit maneuver.

6. In general, face presentations contraindicate the use of forceps.

7. Contracted pelvis contraindicate the use of forceps unless sufficient molding has been allowed to take place, and it is evident that slight traction by forceps will suffice to deliver the head.

A. Careful detail should be given to the preparation of the patient and the same strict aseptic technic as for any major surgical operation should be carried out in minute detail. The patient should be completely anesthetized and in case of slight disproportion between the diameters of the head and the pelvis, the modified Walcher position should be utilized. The patient should be catheterized.

B. Accurate diagnosis of the position of the fetus should be made. The forceps blades should be applied over the parietal bosses in all cases. If the forceps blades are properly applied they will lock in position without the use of force.

C. After forceps are applied traction should be made gently at intervals of about one minute. In the interim the forceps should be unlocked. When traction is being applied it should always be in such a manner that the curve described by the blades corresponds to the curve of the pelvic canal, thereby preventing damage to the maternal soft parts.

The above are recommendations made by a Special Committee of the Staff of Grace Hospital, Detroit. While they outline the policy and practice of that hospital, our members in their private practice may well be governed by them. Other hospitals can well formulate a similar policy if they have not already done so.

It is very palpable and apparent that there is much meddlesome obstetrical interference. There is a pronounced tendency toward operative deliveries. There are far too many Cesaerean sections—75 per cent of sections done are unnecessary. There are too many so-called obstetrical specialists, who have nerve to charge large fees and very little real ability to justify those fees. There are too many doctors attending deliveries who are quite ignorant of the physiology and mechanics of labor. A halt, an about face and better service is needed. These rules will help if you observe them.

A SHORT HISTORY OF THE WAYNE COUNTY MEDICAL SOCIETY

JAMES E. DAVIS, A.M.M.D.,
(Chairman Board of Trustees, Wayne County Medical Society.)

Two hundred and twenty-six years ago Dr. Antoine Forrestier came from France with Cadillac to be the first white man to practice medicine in Detroit from 1701 to 1716. Eight years after Dr. Forrestier's death in 1716, Dr. Joseph Lovell became the first Surgeon General of the United States. He had been interested in some problems of the digestive tract and in 1824 a letter was sent to Dr. William Beaumont, Army Surgeon, stationed at Fort Mackinac, asking whether the stomach digested articles of food one at a time or one after another, disposing of beef first, then potatoes, and next fish, cabbage, and finally pudding. Beaumont's answer was given to the Medical Recorder (1825) for publication and was credited to Surgeon General Lovell, but the error in authorship was soon after corrected. The answer set forth the fundamental principles of gastric digestion about as we know them today.

The studies of Beaumont upon Alexis St. Martin's fistulous stomach were so accurate that the reliability of his work withstands the test of time.

The first organization to recognize Beaumont's researches was the Medical Society of the Territory of Michigan, and March 3, 1825, on motion of Dr. Pilcher, the epoch making work of Dr. Beaumont was recognized by unanimously electing him to honorary membership in the Society. The record of this election at Detroit and the notification was made by Dr. John S. Whiting, Secretary.

The first medical organization of the City of Detroit was formed in 1846 and it was named the Sydenham Society.

In 1849 was formed the first organization named the Wayne County Medical Society.

In 1853 there was formed the Detroit Medical Society but this disbanded in 1858. From 1858 to 1866 there appears to have been no society capable of leaving a record of existence. But in 1866 Wayne County Medical Society number two appears in the record but whether as a resucitation or a creation I have been unable

to ascertain. Its activities appear to have ceased in 1876. In 1902 Wayne County Medical Society, number three was formed and incorporated. The meetings were held in the Griswold Hotel at Griswold and State streets.

In this period there was also the Detroit Medical and Library Association, a vigorous and aspiring society with a fair sized small library. Its meetings were held directly across Gratiot avenue to the south of the old public library or on the site of what is now the Crowley Milner Company building. After a period of spirited courtship these two societies were wedded and took the name of Wayne County Medical Society. From this period forward to the present the organization has steadily progressed.

The meetings of the Society after union of the two branches were held in the Stevens Building, Washington Boulevard. Then in the County Building.

In 1909 a permanent home was purchased at 33 High street, East, and five years later a new auditorium was added to the building. The first meeting in the new and at that time commodious quarters was held February 2, 1914. In this fine old residence and hall the society meetings were held weekly and here many attractive cub features were developed. In the past eighteen years a new spirit of fraternity and mutual respect has influenced the Detroit profession; proving, that to know a man better, is to respect him more.

Among the society's many stalwart, vigorous leaders who are now dead, may be mentioned McGraw and Wyman, presidents of the two rival medical schools. Donald MacLean and Frothingham who had recently come as belligerents from the University of Michigan faculty. There were H. Keifer, E. W. Jenks, H. O. Walker, H. Longyear, J. J. Mulheron, L. Connors, J. H. Carstens, E. L. Shurly, David Inglis, E. A. Chapaton, and others —excellent debators, impressionistic and abiding personalities.

H. L. Obetz and R. C. Olin, were the advocates of the Homeopathic viewpoint.

There have been other Detroit societies with limited memberships, functioning for many years. Among these may be mentioned the Detroit Academy of Medicine, (1868-1927), the Detroit Medical Club, (1906-1927), etc.

In 1906 the Defense League became an integral part of the County Society. In 1910 incorporation was accomplished and later library privileges were added and a trained librarian was employed.

During the World War more than 30 per cent of the members gave military services and two, Doctors Post and Vaughan, gave the supreme sacrifice of life. As a permanent memorial to the men who gave service at home and abroad the residue of the society's war fund was placed at interest to be used perpetually as a Beaumond Lectureship Foundation Fund by which a series of three lectures have and will be given annually by distinguished members of the profession. These lectures have been published annually in book form. This fund stimulated gifts for other foundations and one of the society's active members by a gift of $5,000 has endowed an Orthopaedic Lectureship Foundation. Other gifts and some bequests have also been made.

Within the past three years the society's membership has numbered over 1,200 and in 1926 was approximately 1,400, obviously the old home had been outgrown.

For some years owing to judicious and careful business methods a strong and commendable financial condition had been developed making possible the acquirement of a very attractive and appropriate home with a beautiful assembly hall in the magnificent new Maccabees Building at Woodward avenue and the Art Center. It has been said that there is no club or other professional society in Detroit more favorably situated and attractively homey. The future history of the society should record events of outstanding significance to Detroit and its medical profession. The first meeting was held in the new home January 4, 1927.

POST-GRADUATE MEDICAL SCHOOL

For the past year a special committee has been investigating and studying the need for providing opportunity for Michigan doctors to pursue post-graduate study. The committee has very thoroughly studied existing conditions and submits its findings in the following report:

Your Committee on Graduate Study for Physicians herewith submits its report:

NEEDS AND DEMANDS FOR POST-GRADUATE STUDY

The conscientious and progressive physician recognizes the fact that the study of medicine is a continuous and strenuous process which begins directly with his freshman year in the medical school and ends only with his retirement from prac-

tice or with his death. The four years of under-graduate instruction in medicine may be regarded as only the foundation of the physician's training. Upon this basic foundation must be builded a subsequent life-time of earnest, intelligent and diligent study. The reasons for this are obvious. Medicine is in its infancy. Its growth and development are rapid, indeed. Through research and investigation new knowledge is being added almost daily to medicine and its specialties. Therefore, the accepted practices of yesterday may be discarded for newer practices of today based upon newer knowledge. The medical porfession is keenly cognizant of this fact and realizes that it must apply itself incessantly to the painstaking study of these newer contributions which mark the daily advancement of medicine. Furthermore, the earnest practitioner of today realizes that it is essential for him to continually brush up on the well established and more permanent facts and practices of medicine. Generally, his daily routine in the practice of medicine is of such a nature that it tends to disconnect him with other facts and practices which are of the very greatest importance.

Again, physicians in general practice frequently decide to specialize along some particular line of medicine. With a view, then, of keeping up with the advancement of medicine and applying newer knowledge of medicine; with a view of brushing up on the well established practices of medicine which are closely interwoven with the daily more or less circumscribed interests and practices of the physician; and with a view of specializing along certain lines that appeal to the practitioner, physicians in general feel that their schooling processes must continue incessantly after graduation from the medical school. Furthermore, they feel that adequate facilities should be maintained whereat this post-graduate study can be done most efficiently. In a very small measure such needs have been met by the establishment of courses either in under-graduate medical schools or in the so-called post-graduate schools of medicine located in the larger cities of our country. Such institutions have, for the most part, not adequately met the problem which confronts the practitioner in his endeavor to keep up to date. *At this time, therefore, there seems to be a real demand on the part of the medical profession for some form of graduate instruction which could enable him to keep abreast of the times or to devote additional time to the pursuit of such subjects in which their practice has shown them to be deficient.* As far as is possible it is obvious that the establishment of centers where such instruction might be given should be geographically central and in connection with institutions which control and see sufficient material to make the courses profitable. It is perhaps but natural for the graduate of a certain institution to turn instinctively to his Alma Mater, or to that institution most closely at hand for the continuance of his medical education.

The large attendance of physicians at the two or three day clinics conducted during the past year at the University Hospital is sufficient attestation to the fact that the medical profession of the State of Michigan is keenly alive to the needs for post-graduate study and of observation, *and that there is a genuine demand on the part of the profession for opportunities and facilities for post-graduate work.*

THE UNIVERSITY OF MICHIGAN'S OBLIGATION IN OFFERING POST-GRADUATE STUDY IN MEDICINE

Experience has conclusively demonstrated that medical schools flourish best as integral parts of Universities. The very fact that scientific medicine is deeply rooted in the sciences of biology, chemistry and physics make it almost imperative that a medical school be a part of a university where these fundamental sciences are maintained. Furthermore, medicine is so closely inter-related with sociology, psychology, in fact with so many of the other departments and professional schools of the university that it is almost mandatory that the teaching of medicine be conducted in the atmosphere of a university. Since the objectives, methods and other procedures for conducting post-graduate work are essentially similar to undergraduate medical teaching and to university teaching in general, arguments need not be presented here to maintain the statement that post-graduate work can be conducted most efficiently in a university's medical school. Furthermore, the teaching of post-graduate clinical medicine can be best done in a teaching hospital connected with the university's medical school. This does not mean that all post-graduate medical study should be conducted at the University's medical school and hospital. There are many centers in this state and nation distinguished for special attainments in the various departments of medicine which should be made accessible for post-graduate study, and to which physi-

cians should be recommended and sent for advanced and special work. The University Medical School in which post-graduate study in medicine is offered and administered should seek and maintain the very closest co-operation with these extra-mural centers with a view of utilizing their facilities. Physicians in these centers who have distinguished themselves might be invited to become extra-mural members of the faculty of post-graduate medical instruction.

Your committee, therefore, recommends that the University of Michigan establishes regular post-graduate courses in medicine. It feels that by virtue of the University's function as head of the educational machineries of the state; by virtue of its medical school and hospital, which are especially organized and equipped for the teaching of medicine, both under graduate and post-graduate; and by virtue of the fact that libraries and many departments of instruction in the university closely related to medicine and which must be utilized in post-graduate study are readily accessible.

In making this recommendation your committee feels that the University of Michigan has an important obligation to the State of Michigan. Society has a right to demand the latest and most scientific practices in both preventive and curative medicine. Unless regular post-graduate study in medicine is provided for, then society loses. It is, therefore, not enough for the state to provide for under-graduate instruction in medicine. The university should see to it that every physician in the state is given an opportunity and is encouraged to keep abreast of the newer contributions to medicine. This is essential in order that Society will be the recipient of the highest quality of medical service.

The advantages to the profession and to the citizens of the state at large should not blind us to the obvious benefits post-graduate development will bring to the medical school and university itself in added reputation and prestige. Michigan, one of the oldest state universities, has engaged the attention and held the respect of the medical world, even through those lean years which the last decade of rapid advancement has not caused to be forgotten. Dean Vaughan for many years advocated affiliations between the medical school and the hospitals of the state, with the view of the establishment of a community interest that he hoped would result in better work in outlying hospitals and increased interest in progressive medicine on the part of the profession. This was really the beginning of the broader plan of increasing contacts that the adventures of other schools and our own experience have made feasible. The agency that brings about such worth-while results assumes quite naturally a very enviable position.

The University of Michigan need not engage in competition, but it should not allow itself to be placed in a position in which it would suffer by comparison. The presence of graduate students will greatly stimulate the teachers of this institution. The best reputation that any teacher can have is through the quality of his students. The potential leaders of medicine are the men whose ambitions and ideals have led them back to the university for a fuller and more complete knowledge.

TYPES OF POST-GRADUATE STUDY

Your committee recommends that in general two types of post-graduate study be arranged. First, short-term courses, especially designed to aid the physician in brushing up on well established medical practices; to help him to become familiar with the very latest contributions to our knowledge and practice of medicine; and to introduce him into some particular specialty in which he may be interested.

Depending on the time that the physician can spare for these courses, they may be arranged in two groups:

(a) Physician's days. One to two day clinics to be given at the University Hospital or at other hospitals in the state. These clinics to be so arranged that well organized and intensive studies can be made of certain phases of medicine, for which there is particular interest and demand. These short periods should be offered monthly.

(b) Four-week programs of study wherein physicians are given an opportunity to cover fairly well one or more subjects in general medicine, or its various specialties. These programs should be offered at least once and possibly twice a year.

Second, long-term graduate study. The second type of post-graduate study for which your committee recommends that provision be made is the long-term—one or two years of graduate study. This type of study and instruction should be similar in methods and contents to that required by the university for advanced degrees. Your committee is of the opinion that facilities already exist in the clinical depart-

ments of the medical school whereby, with the proper organization and direction, programs of study leading to the Master of Science degree may be readily arranged with but little additional expense to the university. The objectives of the long term of graduate study should be to turn out research workers, teachers and clinicians of the very highest order, men who by virtue of this long training should be capable in every respect of advancing medicine and its specialties. They should be able to establish genuine leadership in their chosen fields. For the present at least, this type of graduate work should be correlated with, and should meet with the fullest co-operation of the graduate school of the University of Michigan. Higher degrees, such as the Master of Science and Doctor of Science and Philosophy, should be conferred on candidates after the completion of prescribed work. This work should be equivalent in every respect to that required for advanced degrees in the Graduate School.

Your committee is of the opinion that both the Medical School and the profession at large will be benefitted immeasurably as the result of the establishment of this genuine graduate work. It should attract many students to the University of Michigan who will in time contribute much to the advancement of medicine.

ORGANIZATION AND ADMINISTRATION OF GRADUATE STUDY IN MEDICINE

In order that this graduate work in both short-term and long-term courses may be provided for in the near future and administered with the greatest possible facility, your committee recommends that the President of the University and tne Board of Regents appoint at an early date a Director, whose duties shall be to organize and direct graduate medical instruction in the University of Michigan. Furthermore, it recommends that a budget be provided whereby graduate instruction may be initiated and maintained. It is obviously difficult at this junction to state just how much money should be included in the first budget. It should be sufficient, however, to pay the salary of a Director, his administration associate, and necessary expenses. Your Committee, therefore, recommends that a Director be appointed first, and that he in conjunction with those concerned prepare a preliminary budget with a view of beginning this work.

In making these recommendations your Committee has purposely refrained from presenting in this report many of the problems and points of view relative to the details of organization and administration of post-graduate teaching of medicine. For example, should an independent faculty and administration be constituted for graduate instruction, as at the University of Pennsylvania, or should it be organized as a part of the Graduate School, as at the University of Minnesota, is an interesting question for discussion. Again, what term should be applied to the short-period courses? Should we designate them as extension courses in medicine, or should the term "post-graduate" be applied to them? Should the caption "graduate study" be limited to the long-term courses which leads to advanced degrees? There are many such details which present themselves. Your Committee feels that these matters and details of organization can be and will be straightened out only after a beginning in organized post-graduate instruction in medicine has been made. It, therefore, earnestly recommends that a start be made along the unpretentious lines recommended in this report. Your Committee is confident that as post-graduate work in medicine grows and develops at the University of Michigan, the more or less complicated matters and details of policies, organization and administration will be worked out satisfactorily to all concerned.

Respectfully submitted,
Douglas Donald, Carl D. Camp,
James D. Bruce.

ENDOWMENT FOUNDATION

In our January issue announcement was made of the formation of The Michigan State Medical Society Endowment Foundation. The articles creating such a Foundation imparted its objects, purposes and administration. These articles having been legaly executed it is now purposed to solicit subscriptions so as to obtain the necessary funds. Our attorneys have supplied us with the following forms:

I give and bequeath (or devise in case of Real Estate ..... to the Grand Rapids Trust company, *In Trust* for the purposes of the Michigan State Medical Society Foundation as expressed in the Trust Agreement dated January 1, 1927.

I hereby agree to pay ..... Dollars to the Grand Rapids Trust company, (in installments ..... Dollars each) *In Trust*, however, for the purposes of the Michigan State Medical Society Foundation as expressed in the Trust Agreement dated January 1, 1927.

In compliance with the above we are now requesting our members and friends to tender their subscriptions. They may be in any amount from $25.00 to $25,000.00, payable in cash payments or by will. Our goal is a Quarter Million Dollar Fund and later a Half Million Dollar Fund. There is opportunity for all: it is desired that every member will have some interest and will have made some contribution.

You who have prospered or who have been fortunate and have attained financial independence—from you we hope that contributions will be fourthcoming in goodly amounts. You who labor constantly and whose financial resources are limited—from you we hope to receive as you are able to give. Send your subscriptions to: Michigan State Medical Society, 1508 G. R. National Bank Building, Grand Rapids, Mich.

And why should you give? We answer by quoting the following paragraph from the articles:

(a) The purposes of this trust are to pay from the net income of the fund or funds held in trust or order of Executive Committee of the Council of The Michigan State Medical Society, for the purpose of providing post-graduate instruction without fee for those designated by said executive committee, to conduct clinics and courses of instruction without fee in hospitals and medical schools in the State of Michigan, and to provide funds either by gift or loan to sustain such persons as are designated by said Executive Committee, during the period of attendance on said post-graduate instruction or said clinics.

Remember that you can specify special or specific purposes as: Lectures or Clinics in Surgery, Medical, Gynecology, Eye Ear Nose and Throat, or any special subject or branch of these general divisions. Remember also that these funds will benefit Michigan Doctors for *all time*, and that your contributions will remain intact for it is only the investment earnings that are to be expended. And so to summarize, you should contribute because:

1. The Foundation provides funds for post-graduate education of Michigan doctors for all time.
2. The Foundation will enable your State Society to aid Michigan doctors to remain abreast of medical progress.
3. Better medical service will be available for the people of Michigan.
4. Our doctors will receive assistance so as to render their work less arduous, and productive of returns that will enhance their material comforts.
5. We will contribute for all time to mankind's welfare.

Our appeal is before you. We await your answer.

WOMAN'S AUXILIARY

The House of Delegates directed that a Woman's Auxiliary be organized in Michigan, complying with the plan and principles of the National Auxiliary of the A. M. A.

President Jackson has appointed the following Organizational Committee:

Mrs. Caroline B. Crane, Kalamazoo, Chairman; Mrs. L. J. Hirschman, Detroit; Mrs. Theo. Kolvoord, Battle Creek.

In due course communications will be directed to County Officers as to the organization of County Auxilaries. Barry County has completed its organization with Mrs. Keller as its President.

In succeeding issues we purpose outlining the plan of Auxiliary work and the progress reports of the Organizational Committee.

THE MICHIGAN STATE MEDICAL SOCIETY'S ORGANIZED FIGHT AGAINST CANCER

REUBEN PETERSON, M. D.,
Chairman for Michigan, American Society for the Control of Cancer
ANN ARBOR, MICHIGAN

The medical profession of Michigan is organizing for a determined fight against cancer. The reasons for undertaking this fight are well set forth in Dr. Soper's article in this same issue.

Cancer in Michigan, as elsewhere in the world, is increasing. It now stands fourth in the order of the most frequent causes of death, being exceeded only by heart disease, pneumonia and cerebral hemorrhage. Over 100,000 persons are succumbing to cancer annually in the United States and probably over 300,000 have the disease at the present time.

There are two principal reasons why the fight against cancer has not been as vigorous as in the case of tuberculosis. First, because of pessimism. The tuberculous patient is always cheerful and optimistic. On the contrary, the cancer sufferer is despondent, thinks there is no hope, easily gives up. Second, in spite of what has been said during the past 15 years, the medical profession itself is pessimistic about the successful treatment of cancer. One is not sold to a proposition unless the salesman believes heart and soul in what he is setting forth. The medical profession here, as elsewhere, has not put the cancer proposition across with the public because it has been doubtful itself.

Why has it been doubtful? Because it has been too impressed with the fatal re-

sults of cancer. There has been too much confusion, running around in circles, chasing after false gods so far as cures are concerned.

Yet the problem is a simple one after all. Early recognition and treatment of cancer, no matter where located, means cure and no return of the disease. Late treatment means the reverse, failure and death. Exceptions, yes, but let these go. General principles must be kept in mind, if we are to retain our enthusiasm and convince others.

To be successful in any health campaign, careful planning and much devoted work are required. It is only through organization that the fight will be won and the Council of the State Society at its annual meeting held at Ann Arbor January 24, 1927, voted to be responsible for and undertake this work, and carry it to a successful conclusion, with the aid of the entire medical profession of the State.

The general plan will be as follows. Each Councilor will organize his own district. He will start with the County Society as a nucleus and ask each County Society in his district to have an active cancer committee appointed which shall aid him in his work. Where an active public health committee already exists, there will be no necessity for the appointment of a special cancer committee unless the County Society so desires.

The County committee will be responsible for the organization of its County in the fight against cancer. It should call to its aid all agencies which have proved themselves of value in various health movements, local Boards of Health, Boards of Commerce, Rotary and Kiwanis Clubs, Womens' Clubs, Nurses' organizations, etc.

With the organization perfected, it is proposed to make the fight against cancer continuous throughout the year, always keeping uppermost in mind that the public should be taught that early recognition of the disease means a cure. However, as a demonstration of what can be done by early examination of those who suspect they have cancer, there will be held in each County in the early part of May next Cancer Clinics, modelled after those so successfully conducted in Detroit under the direction of the Wayne County Medical Society and the Detroit Board of Health.

The staffs of the Hospitals in which these free Cancer Clinics will be held, will be asked to co-operate with the County Cancer Committee and the Councilor of the district whereby the greatest number of persons suspecting they may have cancer, can be carefully examined and advised.

During the week of the Cancer Clinics, talks about cancer will be given before local and lay organizations. These can be arranged for by the County Committee and their local sub-committees.

Supervised publicity will be arranged for through the Publicity Committee of Public Health Educational Committee. It is assumed that the State Board of Health will be heart and soul behind the movement to lower the cancer death rate and that it will furnish cancer statistics, as it has in the past, showing what inroads the disease is making in the different Counties of the State.

It is proposed that careful records be kept of patients examined at the various cancer clinics, during the week of demonstration in May. These records will be sent to a central bureau where they will be compiled and the results tabulated.

Such in brief is the plan of the cancer work undertaken by the Council of the State Society. The Council does not expect to accomplish wonders the first year. It fully realizes that the fight against cancer has only just begun and that to be effective it must be long and persistently continued. It asks the members of the State Society for full hearted co-operation in this movement. If this support be given, it has no fear of the outcome, but will look forward with confidence to the opportunity of demonstrating what can be accomplished in a fight against a common enemy, conducted by an united State medical profession.

COUNCIL DINNER CONFERENCE

In conformity to a policy adopted the Council invited to a dinner conference, representatives from our medical colleges, State Board of Health, State Board of Registration and our standing committees. This was held in Ann Arbor at the Michigan Union on the evening of January 24th.

The following is a copy of long hand notes taken and reflect to a measure the expressions that were made. They are imparted to indicate to our members the trend of thought that resulted.

Dr. Stone, in opening the meeting, said:

Last year closely identified interests met for the first time to discuss common problems. Representatives from the State Medical Society, the Board of Health, University of Michigan, and the Detroit Med-

ical College were represented and an enthusiastic meeting was held.

Doctors Cabot, Jackson and Darling emphasized the need for closer co-operation. Dr. Cabot told of the need for a closer relationship between the public, the profession and medical schools. Dr. Bidddle, of Detroit, stated that the time had arrived when the University should recognize its obligation to provide postgraduate work. As a result of this meeting and these comments a committee was appointed representing the University of Michigan, the Detroit College of Medicine and the State Medical Society, and this committee is to report this evening.

In addition to the consideration of this post-graduate report, the program this evening will take up the operation of the State Board of Registration with reference to the Medical Practice Acts. Before considering either of these questions, I shall call upon Dr. Jackson, President of the State Society.

Dr. Jackson—(Dr. Jackson's report was read—see Editorial in this issue).

Dr. Stone—This report has given us much food for thought and it is my hope that every one present will render an opinion upon the subjects taken up by Dr. Jackson. I shall now call upon Dr. Warnshuis to discuss the Medical Practice Acts.

Dr. Warnshuis—Organized medicine exemplifies both an individual and collective service to the people and to the profession. It embodies two ideals. First, service to the lay public which includes education as to the truths of science and as to the increase of longevity and efficiency. Second, continued interest in the doctor's progress from the day he leaves the medical school and throughout his practice. The tendency of doctors is one of stagnation. There is great danger that he will succumb to the desire for physical comforts. Organized medicine must make men render that type of service to which the public is entitled. The Medical Society has found a weak spot in the State Board of Registration in medicine. As the Board now functions, it is only a formal affair holding three examinations yearly.

We should cause the Board to be more than an examining body. It should have a full time officer as administrator of the Board's affairs. There should be a censor of men in practice. There should be exercised both an educational and mandatory influence which will result in facilities for education and see to it that men in the field will use these facilities to re-prepare themselves in certain cases for practice. The Legislature and the Governor are sympathetic. If proper representation is made standards will be brought to a high level and the people will be rendered service.

Dr. Stone—We will now listen to the report of the Committee on Post-Graduate Education of which Dr. Bruce is chairman.

Dr. Bruce—The information used in compiling this report was derived from a number of sources. These include the Council on Graduate Instruction of the American Medical Association, the Faculty of the University, and through discussion with various members of the profession throughout the state.

Questions were sent out covering the problems under discussion. The following are the conclusions drawn by your Committee:

(Dr. Bruce read the Committee's report —See Editorial).

Dr. Stone—We have listened to a very interesting report from the Committee on Post-Graduate Work. This Committee includes Dr. Bruce, Dr. Douglas Donald, and Dr. Camp. All of us are interested in what Dr. Little has to offer with reference to this report.

President Little—There is no question but what the report has shown the need for graduate work. I feel that you are right in suggesting that a qualified man be put upon this problem during its formative stages. This man should travel and get the views of those in the state.

The report should be put up to the Regents for the purpose of familiarizing them with its contents and for discussion. The question of graduate study is one which should be approached with extreme caution. If successful, it will be one of the greatest contributions. But if it fails, it will cause a rupture between the medical men and the higher institutions of learning in the state.

The short term course will function to brush up the doctor's knowledge and the long term course will function to change his point of view. The long term courses are the important ones since they are the means of bringing the gap between medical science and the basic sciences such as chemistry, physics and biology. The man taking the long term course comes in with a record of service to humanity and gives a strong note to research in chemistry, physics and biology, thereby strengthening such research.

We will better learn how to train under-

graduates through the training of graduates.

The idea of the advanced degree is excellent. Too few men have gone into pure science from medicine or have gone into medicine from pure science.

The Simpson Memorial is another agency whereby the above groups will meet on common ground to solve the problem of pernicious anemia.

Graduate work is a tacit admission of the inter-relationship of one science with another. I shall give this work consideration and hope to make some provision in the budget.

Dean Cabot—I am entirely in sympathy with this type of work. None of the difficulties are insuperable.

Much machinery now exists in the graduate school, but too few men have been taking the work in medicine. Dean Lloyd is familiar with our problems and is very cordial to this work.

The shorter courses offer more difficulty than the long term course. It is not always true that the undergraduate teacher is a good graduate teacher. More men are suited to give graduate instruction.

It is a strain to give both types of instruction. The point of view is different. In the future we may find it necessary to add extra-mural teachers for two reasons: First, so that the present teachers will not be overloaded, and second, to give the graduate students the advantage and benefits of different views. In Boston, often the popular undergraduate teacher proved to be a failure in graduate work. While it is true that the separate faculty policy is ultimately sound, it should be reserved for a considerably future time. We must go forward slowly until we have had more experience.

Dr. Camp—Dean Cabot is correct in his statements with regard to a separate faculty. Instruction should be given by men of mature experience.

The most desirable post-graduate student is a comparatively young man who has been in practice four or five years. Such a man for various reasons usually objects to the expense. Therefore, the fees should be kept at a very minimum or fellowships granted or they should be allowed to pay for the course by assistance.

Dean McCracken—No one can disagree with the report. Two questions arise. First, the question as to the long term of course. It is the function of the University and no one lese to carry on graduate or long term work. The Detroit Medical College does not do it. I am in favor of a school of post-graduate medicine at the University in which advanced degrees will be given after three years' work. Whatever is in the Detroit Medical College is at the disposal of the University. Any material or equipment is the University's. The question of the short course is different. I hesitate to call them post-graduate courses. Generally they are only review courses or courses which men who graduated twenty or twenty-five years ago did not get. The applications at the Detroit Medical College show that men asking for review courses don't know what they want. They show an insatiable appetite for gross anatomy and morbid histology. Many have never had histological training.

I am unable to see why the man who practices internal medicine and obstetrics as a side line should make a dissection during a short course. I wouldn't survive the shock if one of the applicants asked for a course in pharmacology and therapeutics. Others want to come into the clinics and acquire all of the medical knowledge of the last few years in the short course.

The Detroit College is unable to meet the demand for review courses. As a result, an organization not connected with the College has been formed in Detroit to develop review work. The Secretary of that organization, Dr. Bemis, is here tonight and I hope you will call upon him.

Dr. Sundwall—Approves report.

Dr. Wile—I have little to add. There is a good deal of graduate instruction now going on in the Medical School, but it is not recognized because it lacks organization. Many departments now have graduate students and the first duty is to organize these groups so that they may be more closely related.

A modest beginning is more likely to bring the greatest success. Those doing undergraduate teaching should not be burdened with graduate work. Ultimately, we can look forward to a graduate school in medicine. Such a school is inadvisable now.

Extra mural teaching would appeal and assure success. There are many men in the state who are particularly gifted and who have achieved distinction in their fields. Such teaching would meet with a sympathetic response.

A full time administrator is necessary if proper supervision is to be given to both the instructors and the graduate students.

Dr. Sturgis—Post-graduate work should

be begun modestly so that it might be well done. They key note is good organization. The man selected to carry on this work must have an understanding of community needs. The whole work may fail if the administrator has not gained an understanding of community needs through general practice.

The University can function better in its service to the community through post-graduate work of this type.

Dr. Bemis—We are not equipped in Detroit to carry on the long term course. I do not agree with the statement that men out of school four or five years will return for this work.

The response to the review courses has been from the general practitioner in Detroit who finds himself drifting towards a certain specialty and wants to improve himself in that speciality. He is not willing to give up practice entirely, but he is willing to give up a half or three-fourths of his day.

The out-of-town men attracted by these courses have come as a result of specific courses being given by certain men.

I agree with Dr. Cabot that most undergraduate teachers cannot do graduate teaching.

Dr. Warthin—There is an enormous amount of postgraduate work not recognized now by the University. There are many students carried in my department, Dr. Novy's department and Dr. Huber's department. At the present time I am giving a half to one hour daily to a pathologist from Ironwood. Others from Grand Rapids and Detroit have also been given our time. This work takes bloody sweat.

Those who come to us do not count as students. They are not mentioned in the catalog. They come free or pay only a small fee. Some come for long periods, and others for only two days to get the spirochete stain.

There is a great demand from all parts of the country. At the present time I have two Rockefeller students and one-third of my laboratory budget is being expended in post-graduate work. This is a most costly type of work. There has never been any budget for it, and while there has been much discussion of this subject, there has never been any action. It has never been attacked from any practical standpoint.

Much of what is today called post-graduate work is nothing more than post-graduate recreation.

Dr. Corbus—All pathologists run to Dr. Warthin. Some opportunity is needed for men in other fields. I am urging that the man in the country be given an opportunity to get what is new in medicine.

Dr. Cowie—I am thoroughly in sympathy with the report of the Committee.

Dr. Canfield—It is apparent that this body is unanimously in favor of post-graduate work. The plans are now nebulous as they should be in the beginning. Work of this type will never be self-supporting and for that reason must have a generous budget.

It is time that the state provided adequate instruction for all graduates in medicine. However, we must be sure that the brush-up courses will not supply half-baked specialists.

Dean Cabot—I do not agree with Dr. Bemis in his statement that men out of school five or so years are not willing to return for graduate work on a full time basis. At present I have five men who have come back after a period of three to fifteen years in private practice. Four more applications have been received and I feel that this tends to show that they will come back.

Dr. Ricker—I am interested in the post-graduate course for the sake of the smaller hospital. There is greater harmony now between the University and the general practitioner than ever before.

The general practitioner is now demanding the best. The University of Michigan Medical School cannot exist without the support of the practitioner and the practitioner cannot exist without the support of the University Medical School. People are beginning to recognize the half-baked specialist and are demanding better service. The doctors must give this better service and they can only give it through the co-operation of the University.

Many patients will not go to a hospital. They want to stay home and the general practitioner must know how to handle them at home. Further, we need medical students in our small hospitals so that there might be an exchange of ideas, we getting from them the latest information in the field of medicine, and they getting from us the results of our practical experience.

Dr. Stone—I am going to say something with reference to the State Board of Registration. I am not going to try to justify the work of this Board in any way. I have been a member for the last three years and during that time, nothing constructive has been done. It is time that it should be.

The makeup of the personnel and the financial conditions have prevented progress. We are unable to pay a full time Secretary and something must be done so that the Legislature will provide more funds. While I have not interviewed Governor Green, it is my understanding that he is favorable to medical education.

The lack of enforcement is very evident but I do not feel that the question of enforcement and policy is one to take up at the present moment without further information.

I shall now call upon Mr. Werle, Secretary of the State Tuberculosis Association, to tell us of the new tuberculosis sanitarium proposed for Ann Arbor.

Mr. Werle—The last Legislature provided a half-million dollars for a new tuberculosis sanitarium. A site has been chosen in Ann Arbor next to the University Hospital. The newspapers and people approved of this site, but there seems to be some trouble ahead. Objections are arising from some sources to the placing of the tuberculosis hospital here. One Senator has introduced a measure before the Legislature to repeal the half-million dollar provision. If this provision is repealed, it will mean of course that no hospital will be constructed. In addition, the people of Howell are afraid that if this hospital is constructed in Ann Arbor, the present institution in that city will be closed.

We average 2,800 deaths from tuberculosis annually in Michigan. Since the standard for hospital beds is one bed for each death annually, that would mean that 2,800 hospital beds are needed in Michigan fo rthe proper hospitalization of tuberculosis. The total number of beds now in Michigan is 2,200. There is no reason, therefore, since the proposed sanitarium will provide about 200 beds, for the abandonment of the sanitarium at Howell. There is a need, it is very evident, for two such hospitals in this state.

The weight of sense lies in putting the new institution in Ann Arbor. The advantages which will accrue from placing the institution here far outweigh any possible disadvantages. We have a site in Ann Arbor, light and heat are available, no buildings need to be wrecked before construction can be started, and, through such a hospital, the opportunity will be given to train undergraduates in the handling of tuberculosis. Dean Cabot assures me that such opportunity is lacking i nall Medical Schools, and if the proposed sanitarium is constructed here, this Medical School will be the first to have proper facilities for instruction in the care and treatment of tuberculosis. Let me say again, however, that I see no need for wrecking Howell.

Dr. Stone—This afternoon the Council went on record as being against the bill to appeal the appropriation. The Council will do everything in its power to defeat this bill.

Dr. Warnshius—I move that this body endorse the report of Dr. Bruce and his Committee and that this report be referred to the Board of Regents for further action.

(Motion passed)

Dr. Jackson—I had a talk with the Kalamazoo representative in the Legislature concerning the bill which provides a half-million dollars for the tuberculosis sanitarium.

The Committee appointed to choose the site was given full power and made their selection of Ann Arbor.

This selection is unwelcome to the people of Howell. What is more important, the Speaker of the House represents Howell in the Legislature. There is some danger that the bill may be passed repealing the appropriation. Every man here should use his influence wit hhis Representative and Senator so that the tuberculosis sanitarium will not become a political football.

Dean McCraken—Mr. Chairman, I would like to have brought up the subject of preceptors for medical students.

Dr. Stone called upon Dr. Cabot to briefly discuss this question.

Dean Cabot—As medical education now stands, the student tends to lose touch between the means and the end toward which he looks. It seems that the schools are not in a position to present the problems of ordinary medical practice. These problems have their economic, sociological, and ethical phases. The close association with older men in disappearing.

I feel that it is not wise to substitute such contact an dteaching for courses being given. However, the student often derives little benefit from his summer vacation. Some of the students do work in hospitals doing perhaps the same thing that we do in the University Hospital, but the majority never get in touch, during their years of training, with medical practice in its bproad sense.

A committee has been appointed to study this subject. The object is to begin the student's association with the practicing physician between the third and fourth

year. Later, we hope to begin this association after the student has completed his sophomore year.

Dean McCraken may doubt whether we can obtain any great number of preceptors. In this respect I may be an optimist but I feel that Dean McCraken is a pessimist. I would have the students go to the small community of two or three thousand. Their association there would shed important light upon their characters and this to me is one of the most importan phases of the preceptor idea.

Few things that we could do would bring the profession closer together and improve it. We could use the profession within an area of 250 miles, not limiting ourselves to Michigan alone but going across the line into other states as well as Ontario.

We can begin this plan in a rather small way. I am perfectly willing to be the goat in trying it out.

Dr. Bruce—Through the preceptor plan, we hope to give the student a little foretaste of his work as a practitioner. In principle, the plan is correct. No material change should be contemplated now in the students training.

The questionnaire which we mailed out in regard to post-graduate work showed some enthusiastic answers with reference to the preceptor plan. All the replies showed an interest and the majority who replied to this questionnaire volunteered to take students. Some were already doing it, and stated that they looked forward to taking students in the summer.

Concerning the question as to whether there are enough practicting physicians in Michigan to take care of the needs, I can assure you that there are enough now to take the whole graduating class from this University with ease.

Dr. Wile—In connection with the preceptor plan, a most important phase has not been discussed. It appears to me that this plan is the only answer to the problem of getting students to go back to country practice. Many communities today are without medical practitioners. They are being cared for through the extra medical cults due to the fact that the student looks without approval upon country practice or practice in a small town.

Dean McCraken—My experience has had to do only with large city practitioners. I feel that students should not be farmed to specialists. The results of our requests that the internists in a large city take students were very unsatisfactory. The internists would not be bothered with students or they took their vacation at the time when students could take work with them or some other reason arose which prevented their acting as preceptors. It is my experience that the country practitioner never does take a vacation.

Dr. McKenzie—One great advantage of the preceptor plan is seen in connection with the psychology of medical practice. All of us have seen the howling success in medicine who is not up to the latest medical science. Through the preceptor plan, the young man will learn about how to handle people.

It is well to talk about elevating medical practice but don't forget about the man who is in practice.

Dr. Cowie—I would like to have Dean Cabot tell us what other states are doing with the preceptor plan.

Dean Cabot—In California some of the seniors are sent out for a month with a preceptor. Good results have been obtained through this plan, and the practical work is very valuable to the student. If they learn no medicine at all, they at least get valuable experience through their contacts.

Dr. Stone adjourned the meeting.

THE JOURNAL

IS

YOUR FORUM—

WE INVITE YOU

TO UTILIZE

IT FOR THE

EXPRESSION OF

YOUR VIEWS

ON

MEDICAL SUBJECTS

MONTHLY COMMENTS

Medical—Economic—Social

It's a trite saying—but things do move and times change with exceeding rapidity. The present generation has witnessed greater progress than have all the preceding generations since the creation of man. We ourselves witness greater progress, the application and perfection of more new facts in one year than did our fathers in a life time. If you think and do as today a year hence—you are slipping! Think that over. A year hence there will be many new things, new facts, new applications and unless you remain informed as to what they are you will be behind and a back number—slipping and slipping fast. That is why we urge and urge that you remain abreast of progress—attend your medical meetings, go to clinics and schools, read your Journals and remain abreast for if you do not a year hence you will be thinking and doing as you are today—you will be behind and—slipping fast. Think it over.

And now comes a limited visioned individual from the bureau of industrial hygiene of the New York state department of labor who recommends: "State Physicians" for small industrial plants. He goes on to state that: Thousands of small factories have no physicians or nurses. The economic struggle is so intense that the services of a physician seems a waste of money. "Where then, he asks, shall the small manufacturer obtain such advice and counsel, if not from the states?" Ye Gods! But why stop there? Why not have the state supply electricity, water, telephone, shower baths, and clean clothing?

This is but another illustration of a doctor, holding a state job, bursting out with a recommendation that exudes paternalism. He is so limited in vision, narrow in perception, void of all other sense of social justice that we pity his condition. We wager he never attended a county, state or national medical meeting.

This issue contains a large amount of detailed information regarding organizational work. It answers the question as to what your State Society is doing. It is well worth your time to familiarize yourself with these reports. We also direct attention to the editorials on Post-Graduate School, Endowment Foundation and Ideals and all the other editorials. Next month we will tell you about our Annual Meeting and our District and County Conferences. We are happy to be able to demonstrate that you belong to a live, going State Society that is continiously concerned with the enhancement of your personal interests. May we have your reaction?

The Council on Physical Therapy of the American Medical Association, on the basis of the present available evidence, is convinced that the sale of generators of ultraviolet energy to the public for self-treatment is without justification. The Council bases its condemnation of the sale of such apparatus for this purpose on the following grounds:

1. The uninformed public could not take the proper precautions in administering treatments and, as a result, severe general burns or grave injury to the eyes might ensue.

2. Those not familiar with the possibilities of such apparatus would be led to place unwarranted confidence in the therapeutic value of such treatment by the claims that might be made in the literature advertising such generators, and to undertake to treat serious conditions not amenable to such treatment.

3. The unrestricted possession of such therapeutic means would tend to deprive people of expert diagnosis by encouraging them to make self-diagnoses.

4. Such practice would encourage the sale of useless and fraudulent lamps which would be advertised as generators of ultraviolet rays, since the public would have no means at its disposal to determine the quality or quantity of the radiant energy emitted by such lamps.

For the foregoing reasons, the Council on Physical Therapy considers as detrimental to public welfare the sale or advertising for sale, directly to the public, of a generator of ultraviolet energy. Under rule 11 of its Official Rules, the Council will declare inadmissible for inclusion in its list of accepted devices for physical therapy apparatus manufactured by a firm whose policy is in this matter detrimental to public welfare.

Of course you noted the green border on your 1927 membership certificates. Somewhere we recall green as being used for the piping of gowns and tassels of caps worn by students graduating in medicine. We desired to ascertain the basis for this color hoping thereby to further justify the use of this color. Consequently we wrote to what has as a rule been an unfailing fount of authentic information. Our hopes are shattered by the following letter. Can anyone else help us?

"We have searched through all of the available literature in this office, but have been unable to find anything that would be of value to you on the subject of green trimming on doctorate gowns. We find that scarlet, lilac blossom, pink, cherry, crimson, blue, purple, brown, gold and white are used for various trimmings, but search as we will, we are unable to discover the slightest trace of green.

"I am inclined to suggest that you admit at once to your Michigan colleagues that the borders were chosen merely because green is the sign of spring, when everything begins to grow again, and that they were chosen with the symbolical idea that they represent the renewed youth of the Michigan State Medical Society under its present management. Beyond that, there is only the old riddle: "What first turns green in the spring," with the answer, "Christmas jewelry."

"With best wishes, I am

"Very truly yours,

Morris Fishbein, M. D."

Beauty parlors—they seem to spring up overnight. In fact we believe there were more beauty parlors opened up last year than gasoline filling stations. In New York city they have now secured a listing in the telephone books as "Der-

matologists." They'll be demanding the same thing in Michigan ere long. Detroit has an inspector—what we need is a state regulation. They are doing business and selling all kinds of junk—skin foods, tonics, creams and what not. Note well the next time you are called to attend a habitue of these parlors and perceive the litter of bottles and jars on the dresser or in the bathroom cabinet—reminds one of the days when doctors believed in poly-pharmacy. Guess it's time we exposed this American graft that is deceiving our women in the same degree as gland transplants delude our senile men.

Barry County has twenty-two doctors. Twenty are members of the County Society. Monthly meetings are held and start with a 6:30 dinner to which the doctors bring their wives. This fall a special assessment was made to raise $150 to defray a weekly advertisement published in the local paper giving the following information: "Names of officers of the Barry County Medical Society and statement of affiliation with the State and A.M.A. organizations." This advertisement, run each week, has made reading space available and it is used by the Society for imparting each week a 500 word article that is educational and deals with medical topics that impart splendid information for the laity. We cite these two activities for they reflect what may be accomplished. Attendance is good by reason of the presence of the ladies who urge their husbands to go; the publicity is nurturing a growing sentiment of public interest and friendliness. Other counties may well emulate Barry's example.

Recently we commented upon the Surgical Conscience—a subject that merits consideration by our profession and our hospitals. We again invite attention to the problem and submit a recent communication from Dr. Dean Bevan:

"I understand that at a recent meeting of the Board of Trustees of the American Medical Association a motion was passed, requesting the Council on Medical Education to emphasize the need of teaching medical ethics to our medical students. I am very glad that this was done. I have, personally, been very much interested in this subject for a number of years and have felt that there is a great need to emphasize the importance of the proper medical conduct in the practice of medicine. I feel that we should teach not only the medical students but we should carry on a continuous propaganda bringing to the medical profession throughout the country the great importance of this subject; at the next Conference on Medical Education I shall present this matter in the Chairman's Address.

"Ten years ago I presented one phase of this subject which had impressed itself very forcibly upon me; in fact, almost haunted me in my everyday work, namely: the subject of Unnecessary Operations and of Incompetent Surgeons. I am mailing you a copy. I wish you would read it and give me your impression of the best method of presenting this subject of medical ethics to the profession.

"With best wishes, I am

"Very truly yours,

Arthur Dean Bevan."

Official Minutes—Mid-Winter Session of the Council

The Council of the Michigan State Medical Society convened at Ann Arbor at 2:30 p. m. on January 24, 1927. The meeting was called to order by the Chairman, Dr. R. C. Stone, with the following Councillors present:

Doctors Stone, Charters, Burke, Powers, Bruce, Boys, Corbus, Cook, Green, Ricker and Mackenzie.

President J. B. Jackson, Treasurer, John R. Rogers, Chairman of the Medical Legal Committee, F. B. Tibbals, and Secretary-

1. The Secretary-Editor present the following as his Annual Report for the year 1926:

SECRETARY-EDITOR'S 1926 ANNUAL REPORT

To the Council

Michigan State Medical Society.

Gentlemen:—

Your Secretary-Editor tenders to you, and through the Council to our members, this Annual Report of our Society's status and activity for the year 1926. For clarity and summarization this report is made to consist of four sections: Financial, Journal, Society and Executive Activities.

FINANCIAL

The following report from the auditors imparts our financial condition:

January 5, 1927

To the Council of the Michigan State Medical Society,
Dr. F. C. Warnshuis, Secretary,
Grand Rapids, Mich.

Gentlemen:

Pursuant to request, we have audited the books of account and record of the *Michigan State Medical Society* for the period from December 27, 1925 to December 29, 1926 and submit herewith our report.

The scope of our examination included a verification of the assets and liabilities of the Society as of December 29, 1926, and a comprehensive test check of the recorded cash transactions, operating accounts and other records for the period, as commented upon more fully throughout the text of this report. Although we did not make a complete detailed check of all transactions and entries, the tests made were, in our opinion, sufficient to determine the general accuracy of the records.

The assets and liabilities at December 29, 1926

are compared with those at December 26, 1925 in the following summary:

ASSETS

	December 29, 1926	December 25, 1925	Increase *Decrease
Cash	$ 550.61	$ 386.00	$ 164.61
Accounts Receivable	1,155.05	1,600.34	445.39*
Securities Owned	22,387.00	8,750.00	13,637.00
Unclipped Bond Coupons	180.00		180.00
	$24,272.66	$10,736.34	$13,536.32

LIABILITIES

Accounts Payable	$	$ 102.17	$ 102.17*
Advance Payments	220.25	397.05	176.80*
Due to Defense Fund		31.00	31.00*
Reserve for Legal Defense	9,298.07		9,298.07
Net Worth—General	14,754.34	10,206.12	4,548.22
	$24,272.66	$10,736.34	$13,535.32

During the year, the cash and bonds in the Legal Defense Fund, formerly held separately by the Fund Treasurer, were combined with those belonging to the Society, and the operation of that fund placed under the Council's control.

A statement setting forth the assets and liabilities of the Society at December 29, 1926 is included in this report subject to the following comments.

Cash on deposit was verified by direct correspondence with the depositary banks and the balances reported were found to be in agreement with those shown by the books of the Society. The recorded cash receipts for the period were traced directly to the bank accounts as shown by bank statements on file and a thorough test check was made of the disbursements therefrom. Such disbursements, were with a few minor exceptions, found to be properly supported with officially signed, cancelled bank checks, invoices or other data.

Accounts Receivable, represented by members' and advertisers' accounts, were proved by trial balance of the individual accounts, although we did not correspond with the recorded debtors to further verify the accuracy of the book records. However, we analyzed the unpaid accounts as to date of charge and have classified them as follows:

Month of Charge		Amount	Per Cent of Total
December	1926	$ 688.04	60%
November	1926	45.00	4
October	1926	51.36	4
September	1926	10.00	1
August	1926	10.00	1
July	1926	29.85	3
January to July	1926	68.25	6
Prior to January 1	1926	252.55	21
		$1,155.05	100%

Securities owned were verified by inspection and are shown at par less an allowance to reduce to cost.

Full provision has been made, as far as we could ascertain, for all known liabilities of the Society at December 29, 1926.

In accordance with the usual policy of the Society, the furniture and fixtures purchased during the period were charged to Society Expense.

We have prepared and include as a part of this report a Statement of Income and Expense for the fiscal period ended December 29, 1926. In addition thereto, we have included a Statement of Cash Receipts and Disbursements of the Legal Defense Fund for the period from March 1, 1926, when the fund was combined with the general fund to December 29, 1926. The balance in the Legal Defense Fund at December 29, 1926 was $9,298.07 as compared with $9,336.80 at March 1, 1926, the difference being the net excess of expenses over income for the period.

We Hereby Certify, that we have audited the books of account and record of the *Michigan State Medical Society*, for the period from December 27, 1925 to December 29, 1926, as herein outlined, and that, in our opinion, based upon the records examined and information obtained, the accompanying Statement of Assets and Liabilities is drawn up so as to set forth the correct financial condition of the Society at the date named and that the relative operating statement is correct.

Very truly yours,
Ernst & Ernst.

STATEMENT OF ASSETS AND LIABILITIES
Michigan State Medical Society
At the close of business December 29, 1926:

ASSETS

CASH		
On Deposit:		
Grand Rapids National Bank	$ 458.82	
The Old National Bank	91.79	
		$ 550.61
ACCOUNTS RECEIVABLE		
Members' and Advertisers' Accounts		1,155.05
SECURITIES OWNED		
Par Value	$23,000.00	
Less: Allowance to Reduce to Cost	613.00	
		$22,387.00
UNCLIPPED BOND COUPONS		180.00
		$24,272.56

LIABILITIES

ADVANCE PAYMENTS		
Members' and Advertisers' Payments		$ 220.25
RESERVE		
For Legal Defense		9,298.07
NET WORTH		
Balance—December 27, 1925	$10,206.12	
Net Income for the Fscal Year Ended December 29, 1926	4,548.22	14,754.34
		$24,272.66

INCOME AND EXPENSE
Michigan State Medical Society
For the Period from December 27, 1925 to December 29, 1926:

INCOME

Membership Dues	$16,628.55	
Advertising Sales	8,415.70	
Journal Subscriptions	7,690.70	
Reprint Sales	1,464.68	
Interest on Investments	918.50	
Profit on Sale of Securities	76.75	
		$35,194.88

EXPENSE

Salary—Executive Secretary	$ 5,500.00	
Salary—Editor	3,000.00	
Salary—Stenographer	1,622.50	
Journal Expense	11,128.32	
Reprint Expense	1,418.36	
Post Graduate Medical Conferences	2,660.48	
Annual Meeting	1,640.55	
Society Expense	1,578.65	
Council Expense	504.26	
Delegates A. M. A.	495.87	
Office Rental and Telephone	715.97	
Postage and Printing	380.70	30,646.66
NET INCOME		$ 4,548.22

SECURITIES OWNED
Michigan State Medical Society
December 29, 1926:

	Rate	Maturity	Par Value	Cost
National Electric Power Company	6%	1945	$ 5,000.00	$ 4,810.00
General Motors Acceptance Corp.	5	1931	5,000.00	4,892.00
Community Power & Light Company	6½	1933	3,000.00	3,000.00
Pennsylvania Gas & Electric Company	6	1940	3,000.00	2,850.00
Michigan Fuel & Light Company	6	1950	3,000.00	2,985.00

United Light & Power Company	5½	1959	2,000.00	1,850.00
Federated Utilities Company	6	1945	2,000.00	2,000.00
TOTAL			$23,000.00	$22,387.00

I am also submitting an itemization of the expenditures incurred against each departmental fund complying with the Budget appropriation adopted by the Council. This supplemental itemization is for the added information of your Committee on Finance.

Attention may well be drawn to the following facts:

1. Our Present Worth is $14,754.34 invested in approved bonds, in comparison to $10,206.12—a gain of $4,548.22.
2. The Medico-Legal Committee has a reserve fund of $9,298.07.
3. The Treasurer and Secretary are under bond to the Society.
4. Funds from dues and for advertising space are received in the form of checks or drafts. These are deposited in the bank. Disbursements are made by voucher signed by the Chairman, Treasurer, and Secretary. At no time is actual currency or coin received, handled or disbursed. This proceedure therefore makes positive accurate record of all receipts and disbursements.
5. Following action of the Council the funds of the Medico Legal Committee were deposited and invested with the general funds of the Society. This made possible a larger security investment and greater interest earnings. Disbursements of this special fund are made by voucher signed by the Chairman of the Committee, Chairman of the ouncil, and the Secretary. The reserve balance is shown in the Auditor's report.
6. The following Budget is submitted for approval for 1927:

PROPOSED BUDGET—1927

Estimated Income:		
3,000 members at $10.00		$30,000.00
Interest on Bonds		1,200.00
		$31,200.00
Expenditures:		
Medical Legal Committee 3,000 members at $2.00	$ 6,000.00	
Journal subscriptions 3,000 members at $2.50	7,500.00	
Rent, Light, Telephone	1,200.00	
Annual Meeting	1,000.00	
Post Graduate Conferences	3,500.00	
Investigations	2,000.00	
Committee Expense	500.00	
Printing and Postage	300.00	
Council Expense	1,000.00	
Delegates to American Medical Association	500.00	
Stenographic Service	2,800.00	
Joint Committee on Public Health	200.00	
*Contingent Fund	4,700.00	
	$31,200.00	$31,200.00

* No appropriation for Secretary.

JOURNAL BUDGET

Income:		
3,000 Subscriptions	$ 7,500.00	
Advertising Sales	8,000.00	
		$15,500.00
Expense:		
Printing and Mailing	$12,000.00	
Wrappers	225.00	
*Reserve	3,275.00	
	$15,500.00	$15,500.00

* No appropriation for Editor's Salary.

DUES

Frequently the query reaches us as to what return does a member obtain for his dues. We have invariably answered by imparting the features of our Society's activities and also urged that if the member would but read The Journal he would from month to month obtain enlightment as to what was being accomplished. This report is purposedly made specific and detailed so as to summarize our reply to such a query. It is hoped that the Councilors will call this report to the attention of County Secretaries in their district urging that it be read at the next meeting of their County Society. In modesty, do we remind our members that what has been wrought was only possible because of the sacrifice of time, contributions of thought and the expenditure of labor on the part of Officers, Councilors and Committees that were unrewarded by money. Had these services been paid for our dues would have been wholly inadequate. If a member will but carefully analyze this report he will perceive that his dues are yielding a handsome annual return that conserves his personal interests.

SUMMARY EXPENSES 1926

Account	Total	Budget	Over	Balance
Ex. Secretary	$ 5,000.00	$ 5,000.00		
Editor's Salary	3,000.00	3,000.00		
Stenog. $1,622.50 Half Chg. to Jour. 1,017.50	2,640.00	2,500.00	$ 140.00	
Postage & Printing	380.70	300.00	80.70	
Office Rental and Phone	716.97	750.00		$ 33.03
Annual Meeting	1,640.55	500.00	1,140.55	
Council Expense	504.25	1,000.00		495.74
Delegate's Expense	495.87	350.00	145.87	
Journal Expense	14,128.32	15,000.00		871.67
Post Graduate Exp.	2,660.48	3,500.00		839.52
Society Expense	1,578.65	1,600.00		21.35
Ex. Secy. Expense	892.65	500.00	392.65	

EXPENSES—1926

	Ex. Secy.	Editor	Stenog.	Postage and Printing	Reprint Exp.	Office Rental and Phone
January—	$ 400.00	$ 250.00	$ 112.50	$ 10.00		$ 36.97
February—	516.00	250.00	117.50	25.00	$ 386.34	40.00
March—	458.00	250.00	117.50	46.00	50.80	40.00
April—	516.00	250.00	105.00	25.00	138.25	40.00
May—	400.00	250.00	125.00	30.00	229.89	40.00

June—					
458.00	250.00	105.00	30.00	46.45	40.00
July—					
458.00	250.00	125.00	20.00	25.60	40.00
August—					
458.00	250.00	105.00	20.00	.....	40.00
September—					
458.00	250.00	105.00	54.70	51.98	100.00
October—					
458.00	250.00	285.00	80.00	99.40	100.00
November—					
458.00	250.00	160.00	10.00	211.50	100.00
December—					
462.00	250.00	160.00	30.00	178.15	100.00
$5,500.00	$3,000.00	$1,622.50	$380.70	$1,418.36	$716.97

DELEGATES EXPENSE—1926

May—		
C. S. Gorsline		$115.43
June—		
A. W. Hornbogen	$148.00	
J. D. Brook	117.44	
		265.44
September—		
C. F. Moll		115.00
		$495.87

COUNCIL EXPENSE FOR 1926

Budget			$1,000.00
February—			
J. B. Jackson	$ 9.45		
U. of M. Union	70.50		
F. S. Baird	16.00		
R. A. Burke	47.22		
J. H. Charters	6.55		
B. R. Corbus	24.00		
O. L. Ricker	17.79		
Annual Meeting—Exp.	28.95		
		$220.47	
March—			
Executive Comm.	78.20		
H. G. Smith	21.73		
J. B. Jackson	12.44		
B. H. Van Leuven	22.88		
		135.25	
May—			
J. H. Charters	18.29	18.29	
October—			
R. C. Stone	75.00	75.00	
November—			
B. R. Corbus	15.00	15.00	
December—			
R. C. Stone	32.75		
U. of M. Union	7.50	40.25	
		$504.26	$1,000.00
			504.26
			$ 495.74

ANNUAL MEETING EXPENSE—1926

June—			
F. C. Warnshuis—Lansing			$ 10.00
August—			
Printing, Telegrams, Notices			20.96
September—			
Registration	$ 45.00		
Camera Shop	8.50		
H. G. Smith	30.00		
House of Delegates and Registration Booth	116.28		
Telegrams	15.52		
Ingham Society	177.11		
		392.41	
October—			
Hotel Olds	251.27		
C. F. Hoover	35.00		
A. P. Johnson Co.	177.00		
Master Reporting Co.	582.61		
C. C. Sturgis	56.28		
F. C. Warnshuis	17.86		
C. W. Rutherford	26.38		
		1,146.40	
November—			
B. N. Colver	6.00		
Hotel Olds	3.50		
Ward-Schopps Co.	21.78		
Quality Sign Co.	39.50		
		70.78	
		$1,640.55	

JOURNAL EXPENSE—1926

January—			
Postage	$ 15.00		
Stenographer	112.50		
Addressograph	2.88		
Printing and Stock	745.07		
		$ 875.45	
February—			
Postage	35.00		
Stenographer	117.50		
Addressograph	5.75		
Printing and Stock	899.18		
		1,057.43	
March—			
Postage	22.00		
Stenographer	117.50		
Addressograph	4.25		
Printing and Stock	803.78		
		947.53	
April—			
Postage	20.00		
Stenographer	105.00		
Addressograph	4.20		
Printing and Stock	895.33		
Binding Journals	15.25		
		1,039.78	
May—			
Postage	17.00		
Stenographer	125.00		
Printing and Stock	733.41		
Addressograph	4.25		
Additional Postage	46.50		
		926.16	
June—			
Postage	23.00		
Stenographer	105.00		
Addressograph	4.35		
Printing and Stock	825.71		
		958.05	
July—			
Postage	17.00		
Stenographer	125.00		
Addressograph	1.73		
Printing and Stock	641.04		
July—			
Postage	17.00		
Stenographer	125.00		
Addressograph	1.73		
Printing and Stock	641.04		
		784.77	
August—			
Postage	20.00		
Stenographer	105.00		
Printing and Stock	887.83		
		1,012.83	
September—			
Postage	15.00		
Stenographer	105.00		
Addressograph	2.08		
Printing and Stock	623.77		
		745.85	
October—			
Postage	30.00		
Printing and Stock	1,013.74		
		1,043.74	
November—			
Postage	22.00		
Addressograph	4.56		
Printing and Stock	900.93		
		927.49	
December—			
Postage	22.00		
Addressograph	.89		
Printing and Stock	904.30		
Cuts	46.12		
		973.31	
			$ 5,487.99
			$11,292.40
Credit for Cuts			164.08
			$11,128.32
Editor's Salary			3,000.00
			$14,128.32

POST GRADUATE CONFERENCE EXPENSES—1926

Budget			$3,500.00
January—			
H. G. Smith	$ 26.00		
C. R. Elwood	11.10		
W. F. English	5.80		
C. G. Grulee	16.00		
Phil L. March	10.00		
W. H. Marshall	2.50		
A. Raymond Moon	6.00		
Stationery	10.25		
		$ 87.65	
February—			
H. G. Smith	46.70		
Hotel Bancroft	8.50		
L. F. Foster	23.25		
G. Van Amber Brown	14.02		
F. A. Coller	16.39		
F. C. Kidner	22.48		
J. Youmans	12.85		
		144.19	
March—			
H. G. Smith	28.11		
L. D. Calls	1.15		
J. B. Jackson	4.00		
A. P. Johnson Co.	10.25		
E. G. Martin	14.02		
P. F. Morse	53.40		
Supplies	3.50		
		114.43	
April—			
H. G. Smith	39.50		
Manuals	209.30		
C. A. Elliott	11.00		
C. F. McClintic	7.16		
J. B. Youmans	8.84		
Telegrams	4.55		
		280.45	
May—			
H. G. Smith	156.71		
F. C. Warnshuis	7.04		
W. H. Marshall	24.84		
C. M. Williams	15.60		
Telegrams	16.69		
A. L. McWhorter	18.15		
B. R. Corbus	19.25		
Stamps	20.00		
		278.28	
June—			
H. G. Smith	82.00		
F. C. Warnshuis	14.70		
G. J. Curry	18.00		
L. J. Goulet	18.08		
		132.78	
June—			
W. H. MacCraken	27.29		
J. B. Marsh	2.50		
A. P. Johnson Co.	25.95		
Telegrams	3.66		
		59.40	
July—			
B. R. Corbus	45.60		
Carl W. Eberbach	30.00		
Geo. E. McKean	22.00		
		97.60	
August—			
H. G. Smith	115.00		
R. S. Cron	75.00		
M. H. Draper	6.25		
J. L. Garvey	110.00		
W. H. Marshall	250.00		
Max Peet	100.00		
		656.25	
September—			
A. M. Campbell	10.00		
Geo. L. Le Fevre	5.60		
G. W. Moll	27.25		
Camera Shop	3.60		
A. P. Johnson Co.	8.75		
		55.20	
October—			
H. G. Smith	168.90		
C. G. Carling	100.00		
W. J. O'Reilly	4.00		
F. C. Warnshuis	10.60		
Telegrams	5.92		
		289.42	
November—			
H. G. Smith	58.00		
B. R. Corbus	38.00		
L. E. McCaffrey	33.24		
Forbes Stamp Co.	3.30		
A. P. Johnson Co.	55.55		
		188.09	
December—			
H. G. Smith	120.00		
F. C. Warnshuis	50.50		
L. J. Hirschman	7.18		
J. B. Jackson	6.85		
L. D. Calls	15.75		
Supplies	.80		
U. of M. Union	117.00		
Telegrams	2.55		
Davis and Ohlinger	3.75		
		324.38	
		1,670.34	
		$2,708.12	
Credits		47.64	
		$2,650.48	

SOCIETY EXPENSE—1926

January—			
L. D. Calls	$ .70		
Insurance	6.60		
Transfer	4.84		
Kardex	466.61		
Insurance	55.00		
Office Furniture and Supplies	60.65		
Telegrams	7.59		
A. P. Johnson Co.	92.70		
		$694.69	
February—			
Supplies	8.41	8.41	
March—			
Supplies	1.35		
Manuals	2.50		
H. G. Smith	5.50		
		9.35	
April—			
Supplies	2.25		
Hondelink & Luther	60.00		
Hotel Rowe	51.75		
A. P. Johnson Co.	25.30		
Supplies	1.00		
		140.30	
May—			
Audit	145.00		
Supplies	3.65		
A. P. Johnson Co.	13.10		
		161.75	
June—			
L. D. Calls	4.50		
Supplies	14.70		
		19.20	
July—			
Dunham & Cholette	75.00	75.00	
August—			
Supplies	3.85	3.85	
September—			
Supplies	25.95		
Ward-Schopps	5.75		
		31.70	
October—			
Supplies	2.29	2.29	
November—			
L. D. Calls	7.55		
Supplies	9.23		
A. P. Johnson Co.	143.00		
Ward-Schopps	66.50		
		226.28	
December—			
Supplies	7.78		
F. C. Warnshuis	20.00		
Clipping Service	2.20		
G. R. Insurance Agency	125.00		
A. P. Johnson Co.	102.35		
		257.33	
		$1,630.15	
Credits		51.50	
		$1,578.65	

THE JOURNAL

The year 1926 witnessed the completion of the Twenty-fifth Volume of The Journal —a quarter of a century of publication.

This last volume consisted of 684 pages of reading matter, approximately 408 pages of advertising and index of 8 pages or a total of 1,100 pages.
The monthly circulation has averaged 3,-250 copies.

With the approval of the Executive Committee a change in style, cover, type and arrangement was effected with the beginning of our present volume. Your Editor spent much time and experimentation in this re-arrangement and feels that the present form enhances the appearance of our publication and reflects to our Society's credit.

The total cost for the year was $14,-128.32. Subscriptions and Advertising earnings were $16,106.40. A profit of $1,-978.08 must therefor be credited for the Journal.

Your Editor is not purposing to comment upon the intrinsic merits of The Journal. Such comments and appraisals must be forthcoming from the Council and our individual members. Our editorial ideals and aims have been and are: To afford a medium for the publication of scientific articles and the recording of scientific progress; the imparting of public health measures and achievements; editorial discussion of scientific advancement, organizational policies and problems, fields of Society endeavor supplemented by comments upon social, economic, and individualistic events, happenings and achievements. The effort was always to interweave a spirit of enthusiasm and increased individual activity on the part of our members to foster fraternalism and the quest for the attainment of better, extended and greater end results that proclaim progress while at the same time commendably acquiting ourselves of the implied responsibilities that warrant our Society's existence and justify its activities; lastly, to cause The Journal to record county and individual effort thereby creating a historical record.

The degree with which these purposes have been attained is not for your editor to appraise. The verdict must eminate from our members. It has also been our desire and purpose to awaken and maintain personal interest by providing an open forum wherein members may voice opinions and suggestions as well as requests and constructive criticisms. In brief we have sought to cause The Journal in full degree to be the official organ of our Society. We may justly point with pride to the sustained interest that has made possible the realization of a worthwhile publication that creditably reflects our Society's progressiveness.

The Editorial duties are not inconsiderable, on the contrary they consume an increasing amount of time. With expansion in size and form additional hours are demanded in editorial preparation of articles, copy, proof reading and contact with our advertisers. Our mailing problem is one that demands close and constant attention occasioned by a large number of change of addresses. Problems that involve policy or that effect individuals or groups are always submitted to the Publication Committee. I record my expression of appreciation for this valued assistance in the editorial direction of the Journal.

SOCIETY

It may be confidently stated that this past year has witnessed our Society recording the attainment of increased organizational activity and achievement. This has been reflected, with a few exceptions, in every component County unit. It is difficult to record in words, that actually visualize the results, all that has been accomplished. From month to month the Journal has contained records and comments on the year's work. In the Annual Report to the House of Delegates further reports were made. It is germane at this time to enumerate the inclusive scope of the year's record of work.

MEMBERSHIPS

On December 31, 1925 our total membership was 3,013. On December 31, 1926 our membership was 3,065 a gain of 52 members. This numerical strength is represented by the enrollment of the following county Societies:

County	1925	1926	Loss	Gain	Deaths
Alpena	20	19	1	.....	1
Antrim, Charlevoix, Emmet, Cheboygan	17	13	4	.....	.....
Bay	61	63	.....	2	.....
Barry	13	18	.....	5	.....
Benzie	1	.....	1	.....	.....
Berrien	32	37	.....	5	1
Calhoun	102	102	.....	.....	.....
Branch	12	14	.....	2	.....
Cass	8	8	.....	.....	.....
Chippewa-Luce Mackinac	21	21	.....	.....	1
Clinton	13	14	.....	1	.....
Delta	24	21	3	.....	.....
Dickinson-Iron	15	17	.....	2	.....
Eaton	23	20	3	.....	.....
Genesee	110	110	.....	.....	.....
Gogebic	22	27	.....	5	1
Grand Traverse-Leelanau	24	26	.....	2	.....
Gratiot-Isabella-Clare	27	28	.....	1	.....
Hillsdale	21	21	.....	.....	2
Houghton	40	41	.....	1	1
Huron	11	8	3	.....	.....
Ingham	92	86	6	.....	.....

Ionia-Montcalm	31	32	.....	1	.....
Jackson	75	65	11	.....	.....
Kalamazoo	111	111	.....	.....	1
Kent	183	190	.....	7	2
Lapeer	21	23	.....	.....	.....
Lenawee	31	29	2	.....	.....
Macomb	33	31	2	.....	.....
Manistee	10	8	2	.....	1
Marquette-Alger	35	33	2	.....	.....
Mason	8	10	.....	2	.....
Mecosta	19	19	.....	.....	.....
Menominee	10	11	.....	1	.....
Midland	7	7	.....	.....	.....
Monroe	25	26	.....	1	1
Muskegon	55	61	.....	6	1
Oceana	7	8	.....	1	.....
Newaygo	9	8	1	.....	.....
Oakland	74	79	.....	5	3
O. M. C. O. R. O.	7	10	.....	3	.....
Ontonagon	7	6	1	.....	.....
Osceola-Lake	.....	1	.....	1	.....
Ottawa	29	28	1	.....	.....
Saginaw	61	57	4	.....	.....
Sanilac	13	11	2	.....	.....
Schoolcraft	5	5	.....	.....	.....
Shiawassee	29	27	2	.....	.....
St. Clair	49	47	2	.....	.....
St. Joseph	19	21	.....	2	.....
Tri	18	19	.....	1	.....
Tuscola	24	22	2	.....	.....
Washtenaw	110	118	.....	8	.....
Wayne	1,188	1,228	.....	40	9
Total	3,013	3,065	55	107	26
		3,013		55	
Gain		52		52	

DEATHS

Official notice has been received of the deaths during 1926 of the following members:

Name	County	City
McDaniels, F. J.	Alpena	Alpena
Gowdy, Frank M.	Berrien	St. Joseph
Bennie, R.	Chippewa-Luce-Mackinac	Sault Ste Marie
Burch, George	Gogebic	Watermeet
Wheeler, A. R.	Gratiot-Isabella-Clare	St. Louis
Bell, T. H. E.	Hillsdale	Reading
Oliver, W. A.	Hillsdale	Camden
Nichols, H. N. T.	Houghton	Ahmeek
Davey, B. M.	Ingham	Lansing
Hamilton, Isiah E.	Kalamazoo	Lawton
Eaton, Daniel R.	Kalamazoo	Kalamazoo
De Vore, James A.	Kent	Grand Rapids
O'Brien, Stephen L.	Kent	Grand Rapids
Welsh, D. E.	Kent	Grand Rapids
Goeke, J. F.	Manistee	Manistee
Horbogen, H. J.	Marquette	Marquette
Southworth, C. T.	Monroe	Monroe
Barnard, J. H.	Muskegon	Whitehall
Bradshaw, B. C.	Oakland	Royal Oak
Le Baron, Robert	Oakland	Pontiac
Orton, Ellsworth	Oakland	Pontiac
James, Wm. B.	St. Clair	Port Huron
Ross, Geo. A.	St. Clair	Capac
Smith, S. K.	St. Clair	Port Huron
Wilson, Purvis S.	Shiawasse	Owosso
Miller, C. E.	Tri	Cadillac
Fleming, W. E.	Wayne	Detroit
Kay, Alex D. W.	Wayne	Detroit
Kenney, George W.	Wayne	Detroit
Mooney, E. W.	Wayne	Detroit
Oakman, Charles H.	Wayne	Detroit
Rich, H. M.	Wayne	Detroit
Seager, Geo. B. M.	Wayne	Detroit
Shaffer, John R.	Wayne	Detroit
Sullivan, D. B.	Wayne	Detroit
Williamson, Hedley	Wayne	Detroit

The passing of a fellow member to that unknown bourne ever records the termination of a life that has been concerned and devoted to mankind. No doctor, great or small, but what sometime or other during the labors of the day performs some human service, contributing thereby to mankind's welfare. Far too frequently do his services of love go unsung and unrecorded. Finally when his day of labor is over, he is laid in his last resting place and none but his immediate family and relatives retain the sacred memories of his life of devotion. It is the irony of fate. As we officially record their deaths, the thought is ever recurrent that we as a profession might well erect a lasting tribute to our fellow members by placing in our Capitol City or on our University Campus a monument, enduring for all time, to our deceased members. In so doing we perpetuate the lives and labors of fellow doctors of medicine who gave of self that all life in our Commonwealth might be enhanced and pursued, safeguarded by the ministrations of scientific medicine.

POST GRADUATE CONFERENCES

Following is a list of Post Graduate Conferences conducted during 1926:

District No.	City	Date
2	Jackson	May 25
4	Kalamazoo	March 16
6	Owosso	December 1
7	Port Huron	December 10
8	Saginaw	December 9
9	Manistee	November
10	Bay City	January 26
11	Fremont	June 2
12	Escanaba	July 27
12	Marquette	July 28
12	Houghton	July 29
12	Ironwood	July 30
13	Cheboygan	June 9
14	Adrian	March 9

It is quite apparent that this feature of education commands the approval of our members as testified to by their enthusiastic support. It is also quite apparent that a continuance of these Conferences is indicated during the coming year. The recommendation is however, that they be limited to one for each Councilor District. Second, that these be supplemented by three Clinical meetings of two or three days duration conducted at the University Hospital, Detroit, Flint and Grand Rapids. Third, that County Societies be requested and induced to hold three or four such Conferences of a whole or half day and that this office arrange a corp of speakers for such county meetings which will be for county members. It is apparent that such a plan will achieve better results, be further reaching and will enhance County Society activity. The need existent is that these Clinical Meetings be extended to the County unit instead of a district.

ANNUAL MEETING

A conference betwen Section officers and the Executive Committee was held on December 9, 1926. Plans for our Annual Meeting were formulated and the dates of June 16, 17 and 18th were selected. Full details as to program, features and ar-

rangements will be published in The Journal.

LEGISLATIVE BUREAU

One of the outstanding accomplishments of the year was the Legislative Conference held in Lansing in November. For the first time in our history representatives from all organizations in the state concerned with medical practice, education, public health and social agencies met to discuss their individual and inter-related legislative problems. The formation of a Legislative Bureau composed of one representative from each organization resulted. It must be apparent that from this association there will eminate a unity of expression and action upon all legislation pertaining to medicine, health and public welfare.

ENDOWMENT FOUNDATION

Following instructions from the House of Delegates your Secretary entered into negotiations with the Grand Rapids Trust Company. As the result of numerous conferences articles of incorporation were drawn up and executed.

The Foundation having been created your Secretary purposes, with the Council's assistance, to solicit bequests and contributions.

RED CROSS EMERGENCY RELIEF

Conforming to the action of our House of Delegates the American Medical Association Red Cross plan of Emergency Medical Relief has been presented to all our component units, and local teams are under the direction of the Secretary and President of County Societies.

The foregoing together with the reports that were made at our Annual Meeting impart the essentials of the year's attainments. In recapitulation they may be enumerated as:

1. Joint Committee on Public Health Education.
2. Creation of a Women's Auxillary.
3. Post Graduate Conferences in Councilor Districts.
4. Post-Graduate Clinic at the University.
5. American Medical Association plan of Emergency Medical Relief.
6. Periodic Physical Examinations—Distribution of the Manual and Examination Blank File System.
7. Creation of a Legislative Bureau constituted from all State Organizations concerned with Medical and Public Health Work.
8. Creation of an Endowment Foundation for Medical Educational Extension work among our members.
9. Instituting the Compilation of a Medical History of Michigan.
10. Conducting a Hospital Survey seeking solution of the problem of Medical Charity.
11. Instituting Investigations of Violations of our Medical Laws.
12. Providing Clinical Instructors for County Programs.
13. Completing a Survey of the Distribution of Doctors throughout the State.
14. Imparting by Counties, existing mortality in the more common diseases preliminary to County surveys of local conditions and instituting measures to reduce this mortality rate.
15. Formulation of a Minimum Program of County Society work.
16. Annual Conference of County Secretaries.
17. Medico Legal Defense for members.
18. The Journal.
19. Our Annual Meeting.
20. Consideration of a Plan and the feasibility of establishing a Post-Graduate all year Medical School.
21. Co-operation with the State Department of Health.
22. Providing Speakers for High School Health Lectures.
23. Correspondence.

This tabulation, especially when one scrutinizes the intrinsic scope of each undertaking, answers in no indefinite terms, the "whats and whys" of our Society's existence, the value of memberships and the year's attainments. Words or figures will never set forth the time devoted to the direction and supervision of the host of attendant details. They do however, set forth the Council's acquittal of the trust reposed.

The progress recorded does not permit us to lessen our functions or limit future building. We have a two fold obligation that is definite in its scope. The education of the Public in regard to scientific medicine and all that it holds for their physical welfare and increased longevity; Second, the education of doctors in order that they may remain abreast of our scientific progress, exhibiting an individual capability so as to render to the public the highest type of efficient service. These two outstanding fundamentals must ever be foremost in our thoughts, deliberations and enactments. They must dominate our policies and direct our undertakings. They supply the ideal and indicate the summit toward which our efforts are to be cen-

tered. In accordance with which I tender the following recommendations:

RECOMMENDATIONS

1. That existing policies regarding our Annual Meeting, Publication of The Journal, Medico-Legal protection, Legislation and scope of committee activity be continued.

2. That one, and in some districts, possibly two, Councilor District Post-Graduate Conferences be conducted in accordance with the details disclosed by the Executive Committee.

3. That modified programs be arranged for County Societies for which this office will arrange for speakers.

4. That the County Societies be urged to continue functioning under the Minimum Program plan and that each Councilor shall present this program to each County Society during the next sixty days.

5. That a continuance of endeavor be evidenced to attain the founding of a Post-Graduate Medical School.

From these general policies there will in course eminate those concurrent executive labors that characterize this administrative work.

COUNTY SECRETARIES CONFERENCE

By reason of the value recorded in previous Secretaries' Conferences, it is recommended that the Executive Committee be authorized to arrange for a Secretaries' Conference during the year 1927.

CONCLUSION

I have purposely with-held the injection into this report of extended comment or recommendation. Our objective and manner of attainment is definitely established. The methods of accomplishment quite naturally develop and confront us as advancement is recorded. Under the advice and guidance of the Executive Committee the details are enacted and procedure defined as each problem or situation is encountered. This is a most satisfactory arrangement assuring supervision that reflects the judgment of five officials, thereby minimizing error in ommission as well as commission.

By way of criticism and general appraisal my contact with our work calls up one general conclusion and observation. We have, as indicated, a definite objective. We have the requisite organizational machinery. Our numerical strength is well nigh 100 per cent. Component units, by reason of excellent work on the part of a few in each County Society, are in a healthy state. But notwithstanding there is a palpable lack of what I term, "the will" to do, for intensive realization. The spirit is palpable but "the will" to enact the spirit is feeble and often times of negative potentiality. We therefore plead for a wholesome development of willingness in order that our State Society may be greater, stronger and broader in value and function.

Lastly, I desire to express and record my personal feelings of appreciation for having been permitted to complete another year of service. The confidence manifested has ever been a source of inspiration. My appreciation is voiced in the efforts expended and the labor that stands recorded.

Respectfully submitted,

F. C. Warnshuis,
Secretary-Editor.

2. The several sections of the Secretary-Editor's report were referred to the Standing Committees of the Council.

3. The Treasurer, John R. Rogers, submitted his Annual Report of the funds of the Society in his possession, confirming the report of the auditors. On Motion of Dr. Corbus, supported by Dr. Powers, the policy of conferring with the Chairman of the Finance Committee and the Treasurer in the investment of surplus funds of the Society was recommended.

4. Dr. F. B. Tibbals, Chairman of the Medical Legal Committee submitted the following as his Annual Report:

Detroit, Mich.,
January 19th, 1927.

To The Council,
Michigan State Medical Society.

The year just past closes seventeen years' work for this Committee with two of the original members stil linterested in the work and the same trial lawyer.

A brief resume may interest the Council and the profession. In these seventeen years, there have been reported to this Committee 439 cases of alleged malpractice, in 216 of which suit has been started and about 50 per cent of the latter were actually called for trial.

But two cases handled entirely by us have resulted in final adverse verdicts and these were tried by high-grade local attorneys, since which time Mr. Barbour has tried all our out of town cases. Several cases defended jointly by ourselves and some Insurance Company have had judgments finally paid by the Insurance Company. There have also been a number of

cash settlements during trial by the Insurance Company and a number of small cash settlements before trial, mostly by the uninsured doctor, either with or without our advice. The largest Insurance Company settlement was $2,100.00. The largest settlement by a doctor was at $1,000.00. The largest verdict rendered was for $15,000.00, the case being still in appeal. The largest judgment paid by an Insurance Company was for $7,500.00. There is a distinct tendency toward larger verdicts and also an increasing percentage of these malpractice threats and suits.

There has been much improvement the past 10 years in the attitude of the profession toward these suits with an increasing unwillingness to mix in a purely legal matter as a witness against a brother practitioner. Medical experts are necessary for the plaintiff to make out a case and in those communities where no local doctor will testify for the plaintiff the suit is seldom tried. A subpoena can force any doctor to testify to fact but not as an expert. In theory the rights of the public might seem jeopardized were every doctor to refuse to testify for the plaintiff in a malpractice suit. But actually the percentage of real malpractice from the medical viewpoint is so exceedingly small that a possible injustice in one just case would be offset by positive justice in 99 other cases. It is a conclusive fact based on the nonsuccess of almost all these suits that almost all of them are essentially blackmail.

As an evidence of the success of our protection, we might mention the statement of the Insurance Company having the largest number of policyholders in Michigan that the cost of defense is lower in Michigan than anywhere else because of the cooperation of the Medical profession. It is our aim to extend protection to our members, even outside of strictly civil malpractice in so far as our funds permit and we have handled with success a number of cases outside the strict malpractice field.

It should always be remembered, however, that statements which cannot be proven, in court if need be, should not be made regarding the character or ethics of another practitioner. Our bank balance seems ample to meet all necessary demand in this and succeeding years.

Respectfully submitted,

F. B. Tibbals, Chairman.
Angus McLean.
W. J. Stapleton, Jr.
James D. Bruce.

5. On motion of Councilor Green, supported by Councilor Cook, the minutes of the Executive Committee as published and the actions therein recorded were approved and made part of the regular minutes of the Council.

6. Dr. Reuben Peterson, State Director of the American Association for the Control of Cancer, addressed the Council on Cancer Propaganda and Methods of Public Education for the State. He made the request that the Council assume direction and control of this educational work in Michigan. The matter was referred, after some discussion, to the Council's Committee on County Societies to report at the Tuesday morning session of the Council.

7. Mr. Werle, Secretary of the State Tuberculosis Society addressed the Council upon the question of the repeal of the bill introduced in our State Legislature providing for a new Sanatorium for tuberculosis in connection with the University Hospital at Ann Arbor. On motion of Councilor Charters, supported by Councilor Burke, the following resolution was adopted:

"That the Council of the Michigan State Medical Society, representing the organized medical profession of Michigan, vigorously protest against any and all attempts that are being made to cause the repeal of this bill thereby preventing the construction of this much needed Tuberculosis Sanitorium.

The Tuberculosis Committee and the Michigan Legislative Bureau shall promtply and vigorously institute such proper representation before our Legislature for the purpose of securing the defeating of the bill that seeks to repeal provisions previously enacted for the erection of this sanitorium.

"The Council further directs that the Secretary shall present this matter to the several component County Societies requesting them through their representative committees to file similar protest with Representatives and Senators at Lansing."

Carried.

7. Communications were presented by the Secretary from Dr. W. A. Chapman and Dr. Ferdinand Cox. These communications were accepted and ordered filed.

The First Session adjourned at 5:00 p.m.

SECOND SESSION

The Council convened in second session at 9:00 a. m., January 25, 1927, with Chairman, Dr. R. C. Stone, presiding and the following Councilors present:

Doctors Stone, Charters, Burke, Powers,

Boys, Corbus, Cook, Green, Ricker, MacKenzie, President J. B. Jackson, Treasurer John R. Rogers, and Secretary-Editor F. C. Warnshuis.

1. Dr. B. R. Corbus, Chairman of the Committee on County Societies, reported as follows:

"Your Committee recommends that the plan for the conducting of District Clinical Conferences and County Society Post-Graduate Conferences, as outlined by the Secretary-Editor in his Annual Report, be approved and inaugurated; we further recommend the approval of the other organizational activities as outlined by the Secretary in his Annual Report.

"In regard to the program of activity for the education of the public in the matter of cancer and early detection of cancer, your Committee recommends in general, that this program be endorsed; that the Council further go on record as endorsing the plan for Michigan as outlined by Dr. Reuben Peterson with the provision that all activities shall be under the direct control of the Council through the Councilor of each district, and that all publicity and supervision of clinics shall be under the direct control of each Councilor for his district."

On motion of Councilor Charters, supported by Ricker, the above report was adopted.

PUBLICATION COMMITTEE

2. The Publication Committee made the following report:

"To the Council of the Michigan State Medical Society: Your Committee wishes to register their appreciation of the excellent condition in which the Journal of the Michigan State Medical Society is today, not only for the gratifying financial profit for the last fiscal year but for the general improvement in quality and interest of the Scientific articles, reports of public health measures and achievements, medical news and editorial comments.

"The Committee approve the change in cover, style, type and arrangement of the last number and recommends its continuance in future issues.

"The Committee also feel that the splendid condition of The Journal is due to the untiring energy and unusual ability of the Editor and take this means of expressing their satisfaction and approval.

Dr. J. D. Bruce,
Dr. B. F. Green,
Dr. Henry Cook."

On motion of Councilor Boys, supported by Powers, the report was adopted.

FINANCE COMMITTEE

3. The Finance Committee recommends the adoption of the budget for 1927 as outlined in the Secretary-Editor's report, and in view of the fact that the budget made no provision for the salary of the Secretary-Editor, this having been left open for the decision of the Council, on motion of Councilor Powers, supported by Boys, the Council fixed the salary of the Secretary-Editor as $3,000 as Editor of the Journal and $1,000 as Secretary of the Society.

On motion of Councilor Corbus, supported by Boys, the budget with the above addition was adopted.

4. On motion of Councilor Bruce, supported by Powers, the Council approved and endorsed the recommendations made by J. D. Bruce and his Committee for the institution of a Post-Graduate School in connection with the University of Michigan Department and directed that the Secretary transmit this report to the President and the Regents of the University with the request that early action be taken to institute the recommendations therein contained.

Carried.

ELECTION

5. On motion of Councilor Charters, supported by several, the Chairman of the Council was requested to cast the ballot of the Council for Dr. F. C. Warnshuis as Secretary-Editor for the ensuing year. The Chairman did so cast and declared Dr. Warnshuis elected.

On motion of Councilor Corbus, supported by Ricker, the Secretary was directed to cast the ballot of the Council for John R. Rogers as Treasurer for the ensuing year. The Secretary did so cast and the Chairman declared Dr. Rogers elected Treasurer.

On motion of Councilor Cook, supported by MacKenzie, the Secretary was directed to cast the ballot of the Council for all the members of the Medical Legal Committee whose terms expired January 1, 1927. The Secretary did so cast and the Chairman declared the following elected as members of the Medical Legal Committee:

F. W. Tibbals, Detroit; E. C. Taylor, Jackson; Angus McLean, Detroit; W. J. Stapleton, Detroit.

There being no further business the Council adjourned at 11:00 A. M.

Frederick C. Warnshuis,
Secretary-Editor.

OUR OPEN FORUM

Affording Opportunity for Personal Expression

WISCONSIN MEETING

Editor of The Journal:

Just a note to advise you that the dates for our next meeting at Eau Claire, Wisconsin, are as follows:

House of Delegates—Tuesday evening, September 20th.

General Sessions—Wednesday, Thursday and Friday, September 21, 22 and 23.

Cordially yours,

J. G. Crownhart, Secretary.

COLLEGE OF SURGEONS

Editor of The Journal:

The American College of Surgeons will hold its 1927 convocation and clinical congress in Detroit and Ann Arbor from Monday, October 3rd, 1927 to Friday, October 7th, 1927. The headquarters will be at the Book-Cadillac and Statler hotels.

The following is the Committee on Arrangements:

Alexander W. Blain, Chairman; Angus McLean, Walter Parker, Harry Torrey, Louis J. Hirschman, Reuben Peterson, Harry Plaggemeyer, Max Ballin, Harper Hospital; Roy D. McClure, Henry Ford Hospital; Hugh Cabot, University Hospital, Ann Arbor; Herbert W. Hewitt, Grace Hospital; Frederick C. Kidner, Children's Hospital; Leo Dretzka, Detroit General Hospital; Walter Hackett, St. Mary's Hospital; Wm. J. Seymour, Providence Hospital; Frank C. Witter, Highland Park General Hospital; Hollister Judd, Woman's Hospital; Ira G. Downer, Jefferson Clinic & Diagnostic Hospital; Joseph Andries, St. Joseph's Hospital; Grover Penberthy, Michigan Mutual Hospital; E. C. Baumgarten, Deaconess Hospital; Burt R. Shurley, Detroit Eye, Ear, Nose and Throat Hospital.

Sub-Committee on Eye, Ear, Nose and Throat:

Burt R. Shurley, Chairman; Don M. Campbell, Walter Parker.

Sincerely yours,

A. W. Blain, Chairman.

Editor of The Journal

I am not writing this for publication as I dislike publicity—but I want to tell you personally what I think of the January number of The Journal of the State Society. I have always valued it. Enjoy reading every copy and get much benefit from it. No doctor in Michigan can afford to be without it. The January copy is even better. Not only is the cover attractive, but the subject matter, both papers and editorials, of much value. I wish to congratulate you and feel that the State Society has reason to be proud.

As I am convalescing from a very serious operation done on me only four weeks ago and am not very strong, my writing is poor and I have no secretary at home, but I want you to know personally that I value and appreciate your efforts. I expect to be at the Battle Creek Sanitarium this Saturday night—for a few days—just how long I don't know. But if you happen to be near Battle Creek, I would like to see you. With kindest personal regards, I am

Very sincerely yours,

W. K. West.

Editor of The Journal:

I am enclosing report of January meeting and the questionnaire you sent me some time ago.

Your letter in answer to my questions regarding the use of the Society dues and your opinion of the formation of the Adrian Medical Society, will be very helpful to me this year. I have also heard from Dr. Bruce and hope to have him attend one of our meetings in the future, in order that he can talk to our members personally. I am also sending him a list of non-members.

In anticipation of the State Meeting at Mackinac Island in June, Dr. S. J. Rubley, of Monroe, and myself, wish to issue a challenge to any member or members of the State Society to a contest on the golf course, we to use the bow and arrow and the golfer to use the tools of his sport in a regular round of 18 holes. We also challenge any other archers who may be there to shoot with us in whatever manner may be best suited at the time.

Hoping this challenge will be directed in the proper channels, I remain,

Sincerely yours,

R. G. B. Marsh,
Secretary Lenawee County.

Editor of The Journal:

The new cover on your January issue is very attractive; but we cannot altogether agree with the theory that it is unethical to put advertising on the front cover, which is the natural inference when advertisements no longer appear there. Your Journal has many excellent features, such as good paper, good print, with the matter segregated under proper headings, such as "Monthly Comments," "County Society Reports," etc. You know just where to find what you want. But we miss the "Council Reports" sent out each month by the Secretary of the Council on Pharmacy and Chemistry. About 50 per cent of the members of your State Society are not Fellows of the A.M.A. and, therefore, have no means of seeing the Council reports unless you print them. Medical Journals which do not have the Council's standards could not afford to print the reports as these reports would often be directed against their own advertisers. The State Journal is the only publication in which all the members of the State Society can secure this information. If the reports take up too much space, would it not be feasible

to give the substance of them under "Monthly Comments?"

You have a good Journal, but may be some of the things we suggest would help to improve it still more.

Very truly yours,

Co-Operative Medical Advertising Bureau,
E. W. Mattson, Manager.

January 29, 1926.

Mr. E. W. Mattson,
Co-Operative Advertising Bureau,
Chicago, Illinois.

Dear Mattson:—

I have your letter of the 28th and note your comments regarding the cover page of our Journal. We did not withdraw the advertisements from the cover page for any ethical reason. It was simply typographical appearance and from the issue that has gone forth we have nothing but 100 per cent of comments and approval.

I note what you say regarding the reports of the Council on Pharmacy. For a number of years I ran these comments, but it just seemed to me that they were of no interest or at least very little interest to our members and were issued in a form and style that was not inducive to their being read. Inquiry established the fact that they were not being read and consequently we have omitted them.

It would seem to me that the Council might, with a little thought and study, adopt a different style of presentation for their reports so as to make them easy reading matter and cause them to arrest the attention of our members. When that is done I will be glad to reinstate them in our Journal.

Yours very truly,
Secretary-Editor.

WASHINGTON ARTICLE IN THE FEBRUARY ISSUE

The following are a few of the comments received:

"Enjoyed the Washington article."—O. L. Ricker, Cadillac.

"The Washington article was fine and interesting."—Woodburne, Hastings.

"Give us more articles like the Washington article in the February Journal."—Marsh, Tecumseh.

Note—We are pleased that the article in question afforded our members so much pleasure. Sure, we will publish more of them provided members will write them—send on your manuscripts.—Editor.

Editor of The Journal:

Since having been elected last fall an honorary member of the Michigan State Medical Society, I have been in regular receipt of that Society's Medical Journal.

At this rather late hour I wish to say that I appreciate this distinct favor and sincerely thank you for it. But owing to failing eyesight due to progressive opacity of the lens, I have been able to give it only a partial or imperfect reading—very much to my regret.

I want also to say that judging from this imperfect reading, you are issuing a fine, up-to-date and progressively scientific Journal, one that is not only an honor to the State Medical Society but to progressive medicine anywhere.

In view of my increasing blindness I feel that I can hardly encourage you to continue your trouble and expense in sending me the Journal. I wish also to congratulate you for the good work you are doing in conducting this outstanding Medical Journal.

Most Sincerely Yours,

John P. Stoddard, M. D.

Editor of The Journal:

Just a line to again thank you for your visit last night. The fellows were all much pleased with the talk you gave us.

The ladies organized an auxiliary with officers as follows: Mrs. Kellar, president; Mrs. Woodburne, secretary; Mrs. Swift, treasurer.

I enclose one or two samples of our medical publicity matter. The roster of names cost us $125 for a year. The health talks are inserted gratus.

Yours most sincerely,

A. W. Woodburne, M. D.

Editor of The Journal:

On March 8th, the Calhoun County Medical Society anticipates entertaining Dr. Elliott P. Joslin of Boston. The Sanitarium is extending a complimentary banquet to all physicians attending the meeting. This banquet will be given here at the Sanitarium dining room at 7 p. m., Eastern Standard time.

We wish you would extend the invitation to all of the members of your county society to attend this meeting. In fact, I think it would be well to put a notice in the Journal. It will be necessary for the doctors who plan to attend the banquet to notify us in order that we may have places reserved for them, otherwise there is apt to be some disappointments. Dr. Joslin's lecture will be given immediately following the banquet. I would be very happy if you could be here in person and bring as many of your friends along as possible.

We also anticipate being entertained by Dr. F. H. Albee of the New York Post-Graduate school with a lecture illustrated by stereopticon and moving picture films. This will be held at the Kellogg Toasted Corn Flake company here. At the same time the Kellogg company anticipates putting on a demonstration of their method and system of caring for their industrial surgical cases. This will be a very interesting meeting and we would also extend the same invitation to members of other county societies to be present. This meeting will be held April 5, 7:30 p. m. Eastern Standard time.

Sincerely yours,

W. F. Martin, M. D.

Editor of The Journal:

Word has come to us that Dr. Joslin, of Boston, Mass., is coming to Battle Creek to speak before our Society on March 8, 1927. His subject will be "The Diabetes of Today." On account of the reputation of Dr. Joslin, as an authority on this

subject, we are extending an invitation to the medical profession in the State to attend this meeting, and owing to the number which are likely to be present it will be well for those expecting to attend to let us know in advance.

It will be an evening meeting preceded by a dinner. Details may be had by writing us.

We also have Dr. Fred H. Albee, of New York city, scheduled for our April meeting, when he will talk to us on ununited fractures.

The Michigan Society for Crippled Children expects to put on a Clinic in this county, at Albion, sometime during the month of May. The preliminary survey of crippled children in this county is now going on.

Yours very truly,

Harry B. Knapp, Secretary.

Editor of The Journal:

I will consider it a courtesy if you will publish this letter in your Journals, as I am anxious to come in correspondence with pathologists and surgeons interested in the immediate examination, by frozen section, of tissue in the operating room and the immediate cover-slip studies of smears from all fluids and pus.

Microscopic examination of stained frozen sections has been possible for more than a quarter of a century. The staining of unfixed frozen sections with polychrome methylene blue and other stains is a well-established procedure. In many operating rooms in university and other large and small surgical clinics, provisions for these immediate diagnostic studies have not only been available, but have been in practical use for years. While, unfortunately, on the other side, this diagnostic part of the operating room is conspicous by its absense in many clinics.

Before 1915 it was rarely necessary for a surgeon well trained in gross pathology to need a frozen section to help him in diagnosis at the operating table. Since 1915, and especially since 1922, the public has becomeso enlightened that malignant disease formally easily recognized either clinically or in the gross, now appears in our operating rooms devoid of its easily reorganized clinical and gross appearance and can only be properly discovered by an immediate frozen section. The majority of operating rooms are not equipped or prepared for this new diagnostic test.

The first essential part for this diagnosis is the technician—one to cut and stain the frozen section, or to make and stain the smear. The second is a pathologist trained to interpret it. It is possible for the surgeon to be all three in himself, and some young surgeons are so equipped. In others it is a dual combination—surgeon and pathologist in one, and the technician. More frequently it is three—operator, technician and pathologist. It makes little difference whether it is one, two or three individuals, providing each has the equipment and training for this most difficult diagnostic test.

In the address as chairman of the surgical section of the Southern Medical Association, I discussed biopsy, and this paper has been published in the Southern Medical Journal for January 1927 (Vol XX, page 18). A report of this paper will be sent to anyone or request. The chief object of this letter is to come in contact with surgeons and pathologists who are sufficiently interested in this problem to discuss it either by correspondence, or by attending a matter in the surgical pathological laboratory of the Johns Hopkins Hospital, either the Monday before, or the Friday after the meeting of the American Medical Association in Washington.

Schools for technicians may have to be established in different sections of the country, and the surgical pathological laboratories of the medical schools and the larger surgical clinics should offer courses in this tissue diagnosis, so that surgeons may learn to become their own pathologists, or pathologists learn the particular needs of the surgeon in tissue diagnosis in the operating room.

It is quite true that when the majority of the public are fully enlightened, the surgeon will see lesions of the skin and oral cavity and the majority of subcutaneous tumors when they are so small that their complete excision is not only indicated, but possible without any mutilation The chief danger here will be a surgical mistake —the incomplete removal of an apparently innocent tumor. There is no necessity here for biopsy. If a proper local excision is done, no matter what the microscope reveals, that local operation should be sufficient. But when lesions of the skin, oral cavity and soft parts are extensive and their complete radical removal mutilating, then there must be biopsy to establish the exact pathology.

In tumors of the breast and disease of bone, for years, the diagnosis could be made clinically, or from the gross appearances at exploration. But now, an increasing number of cases, the breast tumor must be explored, and the gross pathology of this earlier stage is not sufficiently differentiated to allow a positive diagnosis. Immediate frozen sections are essential to indicate when the complete operation should be done. The same is true of the earlier states of lesions of bone. The X-rays no longer make a positive differentiation between many of the benign and malignant diseases, for example, sclerosing osteomyelitis and sclerosing osteosarcoma.

We must not only specialize in tissue diagnosis, but we must organize this department so it will function properly in as many operating rooms as possible in this country.

Then there is a final and most difficult question to consider. I doubt if it can be settled. What shall bedone in those operating rooms in which there is no technician to make the sections and no-one trained tot interrpet the microscopic picture? How can a piece be excised or a tumor removed, for example, from the breast, and this tissue sent to some laboratory for diagnosis without incurring the risk of the delay to the patient. I have discussed this point in my paper on biopsy.

Joseph Colt Bloodgood,

Surgical Pathological Laboratory,

Johns Hopkins Hospital.

NEWS AND ANNOUNCEMENTS

Thereby Forming Historical Records

Dr. J. D. Bruce spent three weeks of February in Florida.

Dr. Burt R. Shurly was elected president of the Detroit Tuberculosis Sanitarium at the January meeting of the board of trustees.

We are in receipt of a card from Dr. Van Leuven of Petoskey stating that he is getting some splendid work in the Clinics of London. The doctor will return the first of June.

Remember the dates of the American Medical Association meeting in Washington, D. C.—the week of May 16th. Make your hotel reservations early.

A news item states that a St. Louis physician was shot because he declined to make a night call. It has been noted since that doctors are now promptly responding to their night calls—because who wants to be shot.

Attention is called to the correspondence column where a communication from the Calhoun County Society announce that Dr. Joslin of Boston will address their meeting on March 8th. The profession is invited.

As a testimonial of esteem and appreciation for the service rendered and time contributed to the work of our State Society, the Council presented a handsome traveling bag to President J. B. Jackson. The presentation was made at the January meeting of the Council.

The following examination dates have been assigned by the American Board of Otolaryngology:

Washington, D. C.—Episcopal Eye, Ear and Throat Hospital, Monday, May 16, 1927 at 9 o'clock.

Spokane, Washington—Saturday, June 4, 1927 at 9 o'clock.

The Board of Trustees, Butterworth Hospital appointed the following Executive Committee for a period of two years: R. B. Corbus, Chief of Staff; F. C. Warnshuis, Vice-Chief; A. J. Baker, Chief of Medicine, R. W. Webb, Chief of Surgery; J. R. Rogers, Chief of E. E. T.; Fred Larned, Chief of Pediatrics; H. S. Collisi, Chief of Obstetrics. James Brotherhood, Vice in Medicine, and A. B. Smith, Vice in Surgery.

At the last annual meeting of the Port Huron Hospital, Drs. R. K. Wheeler and George Waters were elected to the board of Trustees.

Dr. R. K. Wheeler was elected Medical Director in my place. I resigned after completing 25 years of service in that capacity.

The hospital during the past two years has done everything required by the American College of Surgeons to place it on the recognized list of hospitals.

Dr. William Derck, Chief of Staff; Dr. A. McKenzie, Chief of Surgical Section; Dr. D. J. McColl, Chief of Obstetrical Division; Dr. D. Patterson, Chief of Urology; Dr. T. Heavenrich, Chief of Medicine, and Dr. George M. Kesl, Chief of Dermatology.

Members of the new medical board of the Woman's hospital of Saginaw, were chosen Monday at a luncheon of the visiting staff of the hospital. The members of the board are Dr. J. H. Powers, Dr. Ralph S. Jiroch, Dr. T. M. Williamson and Dr. H. B. McCrory to serve for three years; Dr. A. R. McKinney, Dr. A. H. Leitch, Dr. F. W. Freeman and Dr. L. C. Harvie, for two years; Dr. Martha Longstreet, Dr. B. B. Rowe, Dr. A. R. Ernst and Dr. G. H. Ferguson, for one year.

Officers selected by the board are: President, Dr. J. H. Powers; vice-president, Dr. G. H. Ferguson; secretary, Dr. H. B. McCrory. Staff meetings will take place either monthly or semi-monthly, with luncheon to be served before the meetings.

DEATHS

Doctor G. W. MacKinnon of Oxford died suddenly Friday morning, January 21, at Lakeland, Florida, where he had gone for a much needed vacation. Dr. MacKinnon was born October 4, 1859 in Port Burwell, Ontario. He graduated from the Bellevue Medical College, New York City in 1890, and practiced in Detroit and Northville and also at Granite, Montana. He also practiced at Orion and from there returned to Detroit, but in 1896 he located at Oxford and for 30 years has been prominently identified with the affairs of Oxford, not only as a physician but as a bank president. During the World War Dr. MacKinnon served as Captain and was a most efficient officer. He was a member of the Oakland County Medical Society, Michigan State Medical Society, American Medical Association and the Military Surgeons of the U. S., and also various Fraternal Orders.

COUNTY SOCIETY ACTIVITY

Revealing Achievements and Recording Service

To County Officers:

During February a letter was addressed to each County Secretary requesting information for our 1927 Post-Graduate Conferences and Clinical Programs for County Meetings. We urge that the information sought be promptly supplied in order that we may formulate these programs and arrange for speakers.

Dues—Members whose dues are unpaid by the end of March are placed on the suspendid list. Please make an effort to get these dues in by March 28th.

Reports—This issue again contains some splendid reports. These County organizations are justifying their existence. Some secretaries fail to send in a report of their meetings—won't every Secretary keep us and their sister units informed as to what they are doing? Please supply us with a report of every meeting.

Secretaries Conference—The Council has directed that we arrange for a 1927 Secretaries Conference to be attended by all County Secretaries and Presidents. We are asking that you write and tell us when and where you want this Conference held. Please express your preference and any suggestions you may have.

JACKSON COUNTY

Officers for 1927 elected December, 1926: President, Corwin S. Clark, M. D., Jackson; Vice-President, James J. O'Meara, M. D., Jackson; Secretary, D. Burr Marsh, M. D., Jackson; Treasurer, F. Gerald Ransom, M. D., Jackson; Delegate, Harold L. Hurley, M. D., Jackson; Alternate, Corwin S. Clark, M. D., Jackson.

D. B. Marsh, Secretary.

CHIPPEWA, LUCE AND MACKINAW COUNTY

At last meeting of Chippewa, Luce and Mackinaw Medical Society the following doctors were elected as officers for 1927: President, C. J. Ennis; Vice-President, E. H. Webster; Secretary-Treasurer, I. V. Yale; Delegate State Meeting, C. J. Ennis, and Alternate, G. A. Conrad.

Very truly yours,

I. Victor Yale, Secretary.

ALPENA COUNTY

On December 16, 1926 at the Annual business meeting of The Alpena County Medical Society the following offiscers were elected: President, Dr. F. J. O'Donnell, Alpena; Secretary, D. W. B. Newton, Alpena; Delegate, Dr. C. M. Williams, Alpena.

I am giving you this for your files and for revision of your list of officers of county societies.

W. B. Newton, Secretary.

GRATIOT-ISABELLA-CLARE CO.

We had one of the most interesting meetings we have had, January 27. When Dr. M. J. Budge talked from notes on how he advised, and treated his pregnant patient from the time she first visited his office on through her confinement and puerperium. The doctor presented the subject in such an interesting way that nearly every one present had something to say in the discussion.

E. M. Highfield, M. D. Secretary.

BERRIEN COUNTY

Newly elected officers for 1927 are: President, R. B. Howard, Benton Harbor; First Vice-President, Orville Curtis, Buchanan; Second Vice-President, H. G. Bartlett, St. Joseph, and Secretary-Treasurer, W. C. Ellett, Benton Harbor.

Have you any more good speakers, that we can get to come down here this year.

We are off with a bang for 1927. January meeting largest in several years.

Give me some help and we will make this territory known for other things than King Ben and fruit.

W. C. Ellet, M. D., Secretary.

SCHOOLCRAFT COUNTY

The Schoolcraft County Medical Society met on evening of January 17, and elected the following officers: President, Dr. J. W. Saunders, and Secretary-Treasurer, Dr. S. Stevens, both of Manistique.

Dr. W. K. Wright was expelled from membership on account of his conviction here in Circuit Court of manslaughter. I will enclose newspaper reports.

I was instructed to bring this matter to the attention of the Board of Registration. How is this done, can it be done from your office?

Yours truly,

S. Stevens, Secretary.

SHIAWASSEE COUNTY

The February meeting of Shiawassee County Medical Society was held at Memorial Hospital, Owosso, on February 1, at 8 p. m. Dr. John Garven, of Ann Arbor addressed the society on "Essentials of Neurological Examinations."

Several cases were presented for examination, to illustrate the subject which was treated in a very instructive manner.

A very good attendance was present from the county and seemed well pleased with the doctor's address.

The nurses' staff served hot coffee and doughnuts at the close of the meeting.

W. E. Ward, Secretary-Treasurer.

BAY COUNTY

A regular meeting with 35 members present was held at the Grotto club Monday evening, January 31. It was addressed by Dr. Burns Amberson, Tuberculosis Consultant, of Detroit. Dr. Amberson gave a most interesting illustrated talk on the "Diagnosis and Treatment of Pulmonary T. B."

Dr. Charles Groomes, F. A. C. S., of Elkins, W. Va., was received into membership.

The society will hold the Tri-County (Saginaw, Flint, Bay City) medical meeting in Bay City, Wednesday, April 27. The speaker will be Dr. Chevalier Jackson, Philadelphia.

L. Fernald Foster, M. D., Secretary.

BARRY COUNTY

We were favored in having our State Secretary with us at our monthly meeting held January 10, Dr. Warnshuis outlined the State Society's program in its varied activities for this year as well as its wider outlook for future years.

The members were very well satisfied with the progress that is being made in the newer fields of activities of our State Society.

The question of free clinics was brought up and discussed. The unanimous opinion of the members present was that the clinical material that shall be brought in, as well as the place and time of holding these clinics, shall be controlled by our County Medical Society.

G. C. Keller, Secretary.

ST. JOSEPH COUNTY

At its annual meeting in January the St. Joseph County Medical Society elected the following officers: President, Dr. C. G. Morris of Three Rivers; Vice-President, D. C. C. Fenstermacher, Three Rivers; secretary-treasurer, Dr. Inez R. Wisdom, Sturgis.

The society meetings for the year were for the most part enthusiastic and the attendance quite satisfactory. Six tri-county meetings were held with the societies of Hillsdale and Branch county and these with one exception were addressed by speakers sent from the faculty of the medical school of the University of Michigan. It is planned to continue these tri-county meetings this year.

Inez R. Wisdom, Secretary.

MACOMB COUNTY

I am writing a report of the doings of the Macomb County Medical Society. The officers for the ensuing year are: President R. W. Ullrich, M. D., Mt. Clemens; Vice-President, W. J. Kane, M. D., Mt. Clemens; Secretary, G. F. Moore, M. D., Richmond, and Treasurer, W. H. Norton, M. D. Mt. Clemens.

Our last meeting was January 3, 1927, at which time we had a very interesting address by Dr. Hugo Freund of Detroit on the subject of Intestinal Diverticula. This address was supplemented by X-ray films and specimens. The attendance, based on the number who paid their dues in 1926, was 70 per cent.

Our next meeting is February 7 at which time we shall have for our speaker, Dr. Charles S. Kennedy of Detroit, on the Surgical Aspect of Skull Fracture with reference to the extra-dural clot.

We are making an active campaign to liven up our society—get all the eligible doctors out.

Very truly yours,

G. F. Moore, M. D., Secretary.

MUSKEGON COUNTY

Regular monthly meeting of the Muskegon County Medical Society was held at the Occidental hotel 6:30 p. m., February 4, 1927.

This was a public meeting attended by members of the Muskegon County Dental Society, Muskegon County Bar Association, and Muskegon Pastors Conference.

Dr. Guy Kiefer, our new state health commissioner gave a very interesting talk on the relation of the state department of health to the physicion of the state. He also outlined the amount and kinds of laboratory examinations being done at the state laboratories. Discussed value of Tuberculosis, Pre-natal and Infant Welfare clinics.

Dr. Marie Kielin, who has just returned from post-graduate study in Europe, was welcomed back into the society.

The society went on record as being opposed to the repeal of the bill establishing a new tuberculosis hospital at Ann Arbor. A copy of this resolution was sent to the senator and representatives from this district.

H. B. Loughery, M. D., Secretary.

OAKLAND COUNTY

A meeting of the Oakland County Society was held at the Board of Commerce, Pontiac, Mich., January 20, 1927. The papers of the evening comprised a symposium on "Backache" led by Drs. R. H. Baker, A. V. Murtha of Pontiac, and Dr. Erwin H. Neff of Birmingham. Much interest was shown by the fact that nearly everyone of the 26 present engaged in discussion.

Three new members were accepted into the society, Drs. Ernest A. Cook, F. A. Fitzpatrick and C. H. Benning.

A new committee on Public Health Legislation was appointed by President Colbin as follows: Chairman, Dr. Shaw of Birmingham, Sutherland of Clarkston. Mercer, Howlett and F. A. Baker of Pontiac.

The matter of Medical Relief in Disaster adopted by the A. M. A. in co-operation with the American Red Cross was discussed and the proposition adopted.

Committees were appointed to write condolences on the deaths of Drs. LeBaron of Pontiac and Bradshaw of Royal Oak.

Following a few brief announcements by the president the meeting was adjourned. The next meeting of the society will be held in the early

part of February, a definite announcement will be made later.

Fred A. Baker, Secretary.

LENAWEE COUNTY

The January meeting of the Lenawee County Medical Society was held at the residence of Dr. H. H. Hammel in Tecumseh.

The meeting was called to order by President Hammel. There were 21 members present. Minutes of last meeting and financial report of the year 1926 were accepted and read.

A motion was made by Dr. C. H. Heffron of Adrian that the Legislative Committee be assigned to the work of gathering all data possible on the status of illegal practitioners in the county and that copies of the state law governing same be obtained and reported on at the next meeting. Carried.

The name of Dr. George Williamsons of Durfield was favorably voted on for transfer from Monroe County Medical Society.

A history of the Lenawee County Society was read by Dr. F. E. Andrews.

This history of the society will be sent in for publication in the Journal at a later date.

The annual election of officers was as follows:

President, H. H. Hammel, (re-elected), Tecumseh; Vice-President, C. H. Heffron, Adrian; Secretary-Treasurer, R. G. B. Marsh (re-elected), Tecumseh, new members of Board of Trustees, C. H. Heffron, Adrian; Delegate to State Society Meeting, H. H. Hammel, Tecumseh; Alternate, R. G. B. Marsh, Tecumseh.

Motion made by Dr. W. S. MacKenzie, that the annual state and county dues of the Secretary be paid from the Society Treasury. Carried.

Meeting adjourned.

R. G. B. Marsh. Secretary.

GOGEBIC COUNTY

The Gogebic County Medical Society listened to an interesting address by Dr. A. J. O'Brien of Ironwood in its January meeting. Dr. O'Brien spoke on his experiences during a recent extended visit in medical centers in Europe, particularly in Vienna. Dr. W. E. Tew was elected delegate to the state convention with Dr. Louis Dorpat alternate. President P. R. Lieberthal appointed the following committees: Constitution, Drs. W. J. Pinkerton, Pierpont, Draper and Lindbohm; membership, Drs. Conley, Madajesky, P. R. Lieberthal, and Harmos; public health, Drs. Prout, W. J. Pinkerton, Dorpat, Hambley, and Hansen; program, Drs. Anderson, O'Brien, Prout, Stebbins, and Tew; social affairs, Drs. Stevens, Maccani, H. A. Pinkerton, and M. J. Lieberthal; periodic health examinations, Drs. Ringo, Urquhart, Tressel, Weaver, and Postle; legislation and prosecutions, Drs. Houghten, Crosby, Krumplebeck; medical defense, Dr. Pierpont.

In the February meeting, which will be held in Grand View Hospital, Dr. P. G. Dick of Chicago will give an illustrated lecture on "Diseases of the Gall Bladder."

Louis Dorpat, Secretary.

Dr. P. G. Dick of Chicago gave a lecture before the Gogebic County Medical Society on February 5 on conditions of the gall bladder. The lecture was illustrated with slides and motion pictures showing X-ray work the lecture.

In the March meeting the principal discussion will be on the value of periodic health examinations. A practical demonstration will probably be given by the committee on periodic health examinations of which Dr. H. F. Ringo is chairman. The committee on constitution of which Dr. W. J. Pickerton is chairman will submit a new constitution for adoption.

Louis Dorpat, Secretary.

HILLSDALE COUNTY

The Annual Meeting of the Hillsdale County Medical Society was held January 28, with election of officers for 1927 as follows:

President, Dr. H. C. Miller, Hillsdale, Mich.

Vice President, Dr. E. C. Bechtol, Montgomery, Mich.

Secretary-Treasurer, D. W. Fenton, Reading, Mich.

Delegate to State Society, Dr. W. H. Sawyer, Hillsdale, Mich.

Alternate, Dr. G. R. Hanke, Ransom, Mich.

Only three members were found willing to undertake educational work—Doctors Sawyer, Green and Frankhouser, of Hillsdale, who each gave an address before High Schools during the month and are scheduled to do the same next month and succeeding months. Reports on dues will appear in the report for February.

D. W. Fenton, Secretary.

The Annual Meeting of the Hillsdale County Medical Society was held at the Mitchell Library on Friday evening, January 28th at 7:00 p. m., the Vice President, Dr. H. C. Miller, in the chair.

Minutes of last meeting read and approved.

The Chairman then introduced Dr. A. C. Furstenburg of the University of Michigan who addressed the society on—"Throat Infection."

Dr. Furstenburg's address was replete with most valuable information for the general practitioner. Eminently technical, it was at the same time most practical along the lines of phrophylaxis, diagnosis and treatment and was listened to with profound attention by the few members present. General discussion and questions followed, all of which were answered by Dr. Furstenburg.

The Chairman in behalf of the Society warmly thanked Dr. Furstenburg for his most valuable address.

The Society then proceeded to the election of officers for 1927. Result as follows:

President, Dr. H. C. Miller, Hillsdale; Vice-President, Dr. E. C. Bechtol, Montgomery; Secretary-Treasurer, Dr. D. W. Fenton, Reading; Delegate to State Society, Dr. W. H. Sawyer, Hillsdale, with Dr. G. R. Hanke or Ransom as alternate.

The Society then adjourned until the joint meeting with St. Joseph and Branch counties.

D. W. Fenton, Secretary-Treasurer.

ST. CLAIR COUNTY

A regular meeting of St. Clair County Medical Society was held at the Hotel Harrington, Port

Huron, Mich., January 20, 1927. After the usual supper and social hour the meeting was called to order by President W. W. Ryerson. The following members were present: Doctors Heavenrich, Callery, MacKenzie, Burley, Patterson, Ard, Vroman, Morris, Derck, Kesl, Wheeler, Waters, Treadgold and Cooper. The minutes of the two preceeding meetings were read and approved. The committee appointed for the purpose reported unfavorably upon the educational advertising plan offered the Society by the local daily. The Banquet committee reported an indefinite postponement of the Annual Banquet until such a time as the roads permitted a full attendance by the rural members. Applications of Drs. L. W. Grice and J. F. Waltz were read and referred to committee. The president appointed a committee of Drs. Wheeler, Vroman and Windham to act with the Free Clinic Association and the Community Chest Organization in the management of the local free clinic now being maintained by these organizations. A general discussion of the clinics now being held and those being proposed, followed. This discussion was led by Drs. Derck, Heavenrich and Treadgold. Dr. Ryerson announced future programs for the meetings of February, March and April. Meeting adjourned at 8:50 p. m.

George M. Kesl, Secretary-Treasurer.

A regular meeting of St. Clair County Medical Society was held at Hotel Harrington, Port Huron, Mich., February 3, 1927. After the usual supper and social hour the meeting was called to order by President W. W. Ryerson. Twenty-one members present. The following guests were present: Dr. Robert Owen of Detroit; Drs. Sykes and Meredith formerly of the Staff of the Henry Ford Hospital; Miss Lucille Roach, Technician in Charge of the St. Clair County Laboratory. Minutes of the preceeding meeting read and approved. Drs. C. F. Thomas, L. W. Grice and J. F. Waltz were elected to membership in the Society. Letter of Secretary Warnshuis relative to legislative action purposing to repeal the Act passed at the last legislature for the erection of a Tuberculosis Sanitarium at Ann Arbor, was read to the Society and the Secretary was instructed to communicate with the Senator and Representatives from this District asking them to defect the Act repealing the erection of this badly needed sanitarium. Letter from Secretary Warnshuis relative to proposed program of the State Society for 1927, was read and referred to Dr. A. J. MacKenzie, Counsillor for the Seventh District.

Dr. Robert Owen of Detroit then read a very interesting paper upon "Blood Chemistry." The speaker covered the following constituents of the blood: Non-protein nitrogen, Urea nitrogen, Uric Acid, Creatinine Clorides, Cholesterol, CO_2 combining power, Sugar, Acetone bodies, Calcium and Bile Pigments. The subject of sugar tolerance was also covered. The paper was discussed by Dr. D. W. Patterson who stressed the fact that while we were taking advantage of some findings in Blood Chemistry we should do so much more frequently. Dr. Owen closed his paper in the usual manner. The Society gave a rising vote of thanks to the speaker for his splendid paper.

Meeting adjourned at 9:00 p. m.

George M. Kesl, Secretary-Treasurer.

KALAMAZOO COUNTY

The forty-third annual meeting of the Kalamazoo Academy of Medicine was held as an all day session December 21, 1926.

The forenoon was devoted to a clinic at New Borgess Hospital held by Dr. G. C. Pemberthy of Detroit. Twelve cases of different types were shown and discussed by Dr. Pemberthy.

The afternoon session held in the Academy room was called to order by the president, Dr. McNair. The secretary's report was read and approved as printed in the bulletin.

Dr. Gregg reporting for the social committee reviewed the work done during the past year and the preparations made for future meetings. He felt that the society was greatly indebted to the Upjohn Company who have so generously fitted up the kitchenette in the Academy rooms, fully equipped the same and supplied all necessary dining room equipment to hold dinners in our own quarters. He suggested that resolutions expressing our appreciation be drawn and sent to the Upjohn Company.

A motion was made, seconded and carried that the report of the social committee be accepted. A motion was also made, supported and carried that resolutions of appreciation be drawn and sent to the Upjohn Company for their kindly interest in, and generous donation to the Academy. The secretary was instructed by the president to draw up and forward such resolutions.

Dr. Shillito reported on the activities of the membership committee and called attention to the new members taken into the society during the past year. He made a motion which was seconded and carried that Dr. Dobson and the staff of the United States Veterans Hospital No. 100 be made honorary members of the society.

Dr. Adams, chairman of the clinical program committee reported two clinics during the past year at New Borgess Hospital. The first, with an attendance of forty, was presented by Dr. Wells of Grand Rapids who showed ten cases. The second held the forenoon of the present meeting with an attendance of thirty, at which time Dr. Pemberthy showed twelve cases.

Dr. Shillito, chairman of the legislative committee, reported on the meeting at Lansing called by the state secretary. It was planned that a joint central committee be appointed to look after the interests of the profession.

Dr. Jackson called the attention of the society to the purpose of the legislative committees of the various county societies. He also stated that a central legislative bureau had been organized with the purpose of co-ordinating all organizations interested in medical matters.

Dr. Shepard, speaking for the anti-tuberculosis committee called attention to the joint meeting held with the Trudeau Society and the efforts made to co-operate with local and state clinics.

Dr. Thompson called attention to the action of the county board authorizing the employment of a nurse to follow up tubercular patients.

A communication was read from Dr. Case relative to his receipt of the bulletin.

Dr. J. E. Maxwell of Decatur spoke about emergency cases which he had brought to Kalamazoo and which he thought had died for lack of blood transfusions. He thought that some standardized provision should be made in the various hospitals to care for patients suffering from shock and hemorrhage. He recommended that a com-

mittee be appointed to look up data on transfusions and provide for donors.

A motion was made, seconded and carried that the president appoint a committee to investigate the status of blood transfusion and report with recommendations.

The chair appointed on this committee:

The Secretary, Dr. R. U. Adams and Dr. R. J. Hubbell.

As no further business was brought before the society, it proceeded to the election of officers for the ensuing year. The chair appointed Drs. Vaughn, Crowell, Squires and Huyser as tellers.

Dr. Crane obtained the floor and after an address of eulogy nominated Dr. C. A. Bartholomew as president of the society. The nomination was promptly seconded by Dr. J. Howard Van Ness.

No further nominations were made and Dr. Collins made a motion that the secretary be instructed to cast one ballot unanimously electing Dr. Bartholomew as president of the society for the ensuing year. Seconded and carried.

Dr. Bartholomew was called upon and gave a few brief words expressing his appreciation of the honor conferred upon him, in particular because of the high standing of the Kalamazoo Academy of Medicine throughout the state.

Dr. Bennett submitted the following report of the nominating committee which was adopted as read.

First Vice-President, Ward E. Collins; Second Vice-Paresident, Norman D. Murphy; Treasurer, R. J. Hubbell; Librarian, A. E. Pullon; Censors, William C. Huyser, R. D. Thompson; Delegates to State Society, Walter den Bleyker and William E. Shackleton; Alternates to State Society, Sherman Gregg and O. D. Hudnutt.

Motion made by Dr. Crane that five dollars be returned to Dr. Case was lost for lack of a second.

The policy of accepting money from non-members was discussed by Drs. Rockwell, Shillito and Bennett. It seemed the concensus of opinion that many men who were not members of the society felt that they would like to contribute something to the support of the society that they might feel free to accept its hospitality. Dr. Bennett said that while he wa streasurer it was his custom to report these men as associates.

The scientific program was carried out as printed in the bulletin, Dr. Pemberthy reading papers on "Appendicitis in Children" and "Acute Osteomyelitis." Both papers were freely discussed and much enjoyed.

At the close of the scientific program Dr. Jackson made a motion which was seconded and carried that the society express its thanks to Dr. Pemberthy for his contribution to our program throughout the day.

The meeting was adjourned until 6:30 p. m. at which time members and friends of the Academy, together with their ladies, met in the recreation rooms of the Upjohn Company where the society enjoyed their hospitality.

Following the sumptious banquet Dr. Light was called by the president to act as toastmaster.

The exaugeral address, "The Truth, the Whole Truth, and Nothing but the Truth," was presented by Dr. McNair.

Mr. A. P. Johnson, of Grand Rapids talked on "Doctors from the Viewpoint of a Layman."

Thus closed the full and profitable day of the forty-third annual meeting.

THE PHYSICIAN'S RESPONSIBILITY IN PREVENTIVE MEDICINE

Practicing physicians are not infrequently criticized by public health officers, welfare workers, publicists and others because of their alleged neglect of anti-smallpox vaccination, antityphoid vaccination, antidiphtheria inoculation, and other practices calculated to prevent disease. The accusation is a challenge to the medical profession. However, the general practitioner should not accept the full responsibility for all these sins of omission. Many of those who now criticize have for some years been "educating" the public to the belief that the public health clinics, health centers, voluntary health bodies and what-not were anxious to render these services "free" to rich and poor alike and that "free" meant both the cost of materials and medical service. Is it not logical to charge part of the disturbing conditions to the error in "education" of the public; to the inadequacy of the free service and materials; to the indifference of an "educated" public?

The physician who has spent thousands of dollars and eight or ten years of his life above high school for his education. who pays his license fees, federal, state, county and municipal and his other taxes, who must spend additional thousands for essential equipment and transportation facilities, who must serve free the poor among his clients, and who must live as other citizens, cannot be expected to compete with "free" services. True, the dispensers of "free" money do, in some places, help the private physician out by supplying some of the materials for some of the services, provided the physician cares to comply with the red tape required to explain the disposition of these supplies, including a certificate that his patient was indigent. These are a few of the many reasons that influence many private physicians in declining to continue in competition with government and voluntary organizations in the rendering of services that every one of our 120 million people needs periodically, and for which those who are able should pay.

Formerly, protective inoculations and similar forms of medical practice were a responsibility of the physician to his clients, with government and other charity-serving organizations looking after the poor. Although most of the controllable infections were among the poor, organizations, government and otherwise, decided to extend their charity to rich and poor alike. After promoting this effort with every means of publicity, some now criticize physicians because many of them discontinued the practice of preventive medicine in the face of such competition.

What the outcome will be of a problem of which this is but one phase, it is impossible to foresee. If only the welfare of 150,000 physicians were at stake, they and their methods might be sacrificed to the common good. But one should be positive that he is on the road to permanent betterment of all the people before proceeding to damage irreparably the existing order. A relationship that would prove mutually helpful to personal physicians and to public health officials and of incalculable benefit to all the people ought to be feasible.—Jour. A. M. A., February 12, 1927.

BOOK REVIEWS AND MISCELLANY

Offering Suggestions and Recommendations

A MANUAL IN PRELIMINARY DIETETICS—Maude A. Perry. Price $1.25. C. V. Mosley Company, St. Louis.

Of value to all students of dietetics.

HOSPITAL HOUSEKEEPING AND SANITATION—Nora P. Hurst, R. N. Price $1.25. C. V. Mosley Company, St. Louis.

Contains much that will be found helpful and pointing to economical saving.

THE SURGICAL CLINICS OF NORTH AMERICA—(Issued serially, one number every other month.) Volume VI, number VI, (New Jersey Number—December, 1926.) 318 pages; 93 illustrations and complete Index to Volume VI. Per Clinic year (February, 1926 to December, 1926.) Paper, $12.00; Cloth, $16.00 net. W. B. Saunders Company, Philadelphia and London.

Continuing to maintain a standard that supplies clinic application of modern principles.

A PRIMER FOR DIABETIC PATIENTS—A Brief outline of the treatment of diabetes with diet and insulin, including directions and charts for the use of physicians in planning diet prescriptions. By Russell M. Wilder, M. D., Section on Nutrition, Division of Medicine, Mayo Clinic. Third edition, reset. 12 mo. of 134 pages. Cloth, $1.50 net. W. B. Saunders Company, Pihladelphia and London.

A manual that should be in the hands of every diabetic under treatment.

THE SPECIALTIES IN GENERAL PRACTICE—Francis W. Palfrey, M. D., Instructor in Medicine at Harvard University in collaboration with 14 other teachers of Harvard Medical School. Octavo of 748 pages. Cloth $6.50 net. W. B. Saunders Company, Philadelphia and London.

This is a unique and satisfying text, that enables one to remain abreast of the numerous specialties as well as indicating how to recognize entities. Every medical man will find in it suggestions and Counsel that will enable him to impart intelligent advice to his patients.

THE CURIOUS LORE OF DRUGS AND MEDICINES THROUGHOUT THE AGES—Four Thousand Years of Pharmacy. Charles H. LaWall. Price $5.00. J. B. Lippincott Company, Philadelphia.

What is a pharmacy? The story is locked up in ancient tomes and forgotten volumes. When we unravel the tapestry into which the picture of pharmacy is woven we find intermingled in the warp and woof the glowing history of an important art, embellished with the golden threads of romance, the black threads of mystery and occultism, and the vari-colored fibres of many allied arts and sciences. The picture is one of which any pharmacist may be proud. In it he will find priest and philosopher, poet and painter, king and pope, knave and charlatan, as practitioners of the art in centuries gone by. Fascinating bypaths leading to forgotten treasures of curious lore await him who strays along the highway of this famous quest, for the search for a panacea, a catholicon, a veritable elixir of life which should cure all ills as if by magic, was the animating motive in the evolution of pharmacy. Astrology and magic also play their parts, and before our eyes alchemy blossoms into chemistry. This fascinating work is the outgrowth of more than 10 years' experience among the advanced students of the Philadelphia College of Pharmacy who have shown interest in knowing more of these "quaint and curious volumes of forgotten lore."

An extremely interesting and instructive recital for which we are all indebted to the author.

SOUTH AMERICA—A guide book for lay and professional travelers, by Franklin H. Martin, C.M.G., M.D., F.A.C.S., in collaboration with William J. Mayo, M.D., Francis P. Corrigan, M.D., and Edward I. Salisbury, M.D. Price, $3.00. Fleming H. Revell Company, publishers, 158 Fifth Avenue, New York City.

The Frontispiece is of the President of the United States, Calvin Coolidge; there is an introduction by Dr. William J. Mayo, and the detailed itineraries which were followed by the contributors to the volume.

First edition, published in 1923, has been completely revised, and amplified to include all of the Latin American Countries. Section I of the book contains a chapter on each of the Latin American countries, with a full and complete description and many illustrations.

Section II contains a summary of the relation of the American College of Surgeons to the Latin American countries.

Section III deals extensively with the Surgeons and the Medical Institutions of Latin America, and is profusely illustrated. Any medical man who contemplates a trip to any of the Latin American countries will find "South America" invaluable.

Section IV contains a complete summary of facts, Historical Geographical, Political, Social and Industrial. In this portion of the book may be found a summary of all information that may be of interest either to the traveler or to the historian.

Section V contains an English-Spanish and English-Portuguese vocabulary which would be most helpful and almost invaluable to anyone contemplating a voyage to Latin America, and both vocabularies are a splendid basis for the study of Spanish or Portuguese.

Section VI contains tables of weights and measures, both the standard and metric systems, and a comparison of the two.

Section VII is a complete index of "South America."

A MANUAL OF PHARMACOLOGY AND ITS APPLICATION TO THERAPEUTICS AND TOXICOLOGY—Thorald Sollmann, M. D., Professor of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland. Third Edition; entirely reset. 1184 pages. Cloth, 7.50 net. W. B. Saunders Company, Philadelphia and London.

It has been the dominant object of this Manual to furnish medical students—including interested

practitioners—an outline of the current conceptions of the actions of drugs, especially from the point of view of their practical importance in medicine. Even with this restriction, the data of pharmacology comprise so many details, that it appeared advisable to make a definite distinction in the text, presenting in ordinary type a fairly concise and connected story of the facts and explanations that deserve study for their direct bearing on medical practice, or for a sound understanding of the subject; and relegating to smaller type the data of less frequent use, or of less immediate importance, which would only be consulted as special occasions arise. This arrangement is facilitated by the paragraph headings. The authors' references and bibliography are also designed to guide the inquirer to further information, rather than for the assignment of credit; although in matters of importance the discoverer is usually cited. Throughout these devices, the Manual was designed to serve as a reference-book as well as text. The author believes that the thoughtful student may be benefitted by feeling that he is in position to confirm and form an independent judgment of the citations; that the practitioner may be helped toward additional information which he may need; and that the investigator may sometimes be saved time and effort.

Since the second edition of the Manual, pharmacologic investigation has continued or rather accelerated its pace. Essentially new drugs have appeared, such as insulin, ethylene, parathyroid hormone, etc. In many subjects, such as the autonomic system, chemotherapy, lead poisoning, etc., new conceptions have come to the front. The changes were so numerous that it appeared advisable to rewrite perhaps the greater part of the important matter. It was practically impossible and appeared scarcely necessary to mention all the newer work along lines that appear at present of minor importance; but the attempt was made to eliminate or revise all parts as were contradicated by more recent data. As it is, some twelve hundred titles have been added to the bibliography.

The appearance of the new (tenth) revision of the United States Pharmacopoeia necessitated a thorough review of the preparations, which have been made to conform with this standard. The nomenclature and spelling have been changed accordingly, including the final "e" for organic bases, halloids, "vitamine," etc.

A NOVEL PROGRAM OF A MEDICAL SOCIETY MEETING

How to conduct an effective scientific program of a meeting of a medical society was beautifully demonstrated on January 29 by the Associated Physicians of Long Island when it carried out a varied program of 18 papers in 90 minutes.

To carry out this program required preparation. The speakers were members of the staff of the Methodist Episcopal Hospital, Brooklyn, where the session was held. Each speaker was required to write his paper within a limit of 600 words. The Chairman appointed a timekeeper who started an alarm clock set for five minutes, and it did not go off once, for every speaker completed his remarks ahead of time.

The program carried this announcement:

"The whole story of creation is told in the Bible in 600 words. Anyone who has a real message to give can do it in five minutes. The presiding officer will be asked to use his gavel if any of the speakers on this program exceeds his time."

The effect of the program was most happy. The one hundred or more physicians who were present gained a wealth of new ideas, and every moment of the time was interesting.

What kind of program was carried out by the meeting? Just such a program as is prepared for an average county medical society. Here it is just as it was printed:

"Subacute and Chronic Sinusitis in Children," Kenneth E. Millan.

Frequency of its occurrence and variety of conditions proceeding from it.

"Gangrene of the Uterus Due to Tortion," Henry T. Hagstrom.

Operation. Case report. Natural color photographic lantern slides.

"Blood Transfusion," Seymour G. Clark.

Indications. Contraindications. Discussion of abuse of the method with illustrative reports and fatalities.

"The Relation Between the Preparation and the Morbidity in Obstetrics," Harry W. Mayes.

Statistics showing effect on morbidity of shaving and cleansing of the external genitalia before using the mercurochrome preparation.

"The Use of the Bronchoscope," Einar A. Sunde.

Indications, contraindications and results in abscess of the lung.

"Exhibition of Interesting Cases," Eugene S. Dalton.

From the medical ward.

"Bone Cysts in Children," Harold K. Bell.

Report of two cases. Lantern slides.

"Manikin Demonstration. The delivery of a face." G. Hamilton Davis.

Presentation with the chin posterior.

"Hare Lip and Cleft Palate," Roger Durham.

When and how to operate. Lantern slide demonstation.

"Umbilical Hernia in the New Born," Ralph M. Beach.

Operation. Case report. Lantern slides.

"Phosphatic Cast of the Bladder," Howard T. Langworthy.

Case report. Discussion of the difficulties in the treatment of alkaline urine. Measures that have been tried. Results.

"Appendicitis Complicating Pregnancy, Labor and the Puerperium," Robert A. Wilson.

Tabloid case reports. Frequency and prognosis and, especially, the treatment.

"Electro-cardiograms," Alexis T. Mays.

Lantern slide demonstration illustrating their

definite value in diagnosis, prognosis and treatment.

"The Use of Radium at the M. E. Hospital," John C. Graham.

Five years' experience. Indications. Contraindications. Results.

"The Kahn Precipitation Test for Syphilis," Esmonde B. Smith.

Experiences in 800 cases at the M. E. Hospital. Conclusions.

"The Use of Numoquin in Pneumonia," Frank B. Cross.

Analysis of results in 200 cases.

"Caudal Anaesthesia for Rectal Operations," Henry F. Graham.

Difficulties. Unpleasant reactions and how to avoid them. Brief statistical review.

"Early X-ray Diagnosis of Infections of the Lung," William H. Wallace.

Lantern slides.

The quality most needed in a medical program is conciseness, in contrast with the prolixity which is often in evidence. To make and carry out a program such as has been described requires only a single essential—that of accurate preparation. Every county medical society has the talent and the clinical cases readily available as the basis for an hour's program consisting of twelve five-minute papers.

TRYPARSAMIDE IN TREATMENT OF GENERAL PARALYSIS

Encouraging results have been obtained by Samuel B. Hadden and George Wilson, Philadelphia (Journal A. M. A., February 12, 1927), in the treatment of general paralysis with tryparsamide, greater than any that they have seen with the use of other arsenicals, mercury or bismuth. Of fifty-two cases, twenty-two patients, with whom contact has been established, can be said to be in fairly good mental and physical condition. The clinical results far surpass the seriologic improvement, which takes place only after very prolonged treatment. One of the best results from the use of tryparsamide is the great improvement in the physical state of the patient, who usually gains weight and appears to be in better general health. The tremor of the face, tongue and lips, and, as a result, the speech defect, is usually considerably bettered. Patients who have been treated with tryparsamide and later have to be institutionalized do not have such a marked tendency toward the formation of trophic cores as those who have not received the drug. The bad effects noted have been small; there were two cases of jaundice, one of dermatitis and two of Herxheimer's reaction, and two patients have shown serious visual defects as the result of treatment. The authors feel that the danger as far as vision is concerned has been overemphasized. Two cases of retinochoroiditis have been treated successfully in this series. The dose of tryparsamide given was 3 Gm., in 10 cc. of distilled water, weekly for ten doses followered by a six weeks' rest.

TOXEMIAS OF PREGNANCY AND TREATMENT OF ECLAMPSIA

J. Whitridge Williams, Baltimore (Journal A. M. A., February 12, 1927), is an ardent advocate of the conservative treatment of eclampsia. He says that in mild as well as severe cases of eclampsia, the results are better under conservative than under radical treatment. In mild cases, a modified Stroganoff technic gives almost ideal results. In severe cases, such treatment gives twice as good results as more radical treatment, but is still followed by a mortality so high as urgently to demand improvement. It appears that all the generally used anesthetics superimpose an additional toxemia on that associated with the disease. Consequently, the operative treatment of severe eclampsia will probably not show better results until some nontoxic anesthetic is discovered. It appears that, after accouchment force, cesarean section performed under the usual general anesthetics is the worst treatment for eclampsia. The necessity for still greater extension of prenatal care is the most efficient means for the prevention of eclampsia. It is necessary to realize that toxemia of pregnancy is a vague general term, and that we have to deal with several types and not with a single one. The treatment of eclampsia must remain empiric and relatively unsatisfactory until the actual cause of the disease is discovered.

CASE OF MATERNAL TETANY RELIEVED BY PARATHYROID EXTRACT-COLLIP

The case reported by Hans Lisser, R. Knight Smith and H. Clare Shepardson, San Francisco (Journal A. M. A., February 12, 1927), seems to be the first one of maternal tetany to be treated with this new extract. The observations and the results obtained justify the assumption that at least certain of the cases of maternal tetany result from an impaired parathyroid activity rather than from an actual paucity of calcium within the maternal organism. The prompt administration of active parathyroid hormone-Collip in adequate dosage, without the aid of any other therapeutic agent, even calcium, relieved the hyperexcitability of the nervous system and caused the calcium content of the blood serum to return to normal (from 7.5 to 9.7 mg. per hundred cubic centimeters).

IS THERE A STANDARD SUPRARENAL EXTRACT?

The pressor principle of the adrenal medulla is best known by its original name—Adrenalin—the name given it by its discoverers in 1900. A variety of other names have been invented to describe this active principle as offered in commrcial form b yother houses; but when the term "Adrenalin" appears in print it is associated in the reader's mind with the house of Parke, Davis & Co.

Adrenalin is not made by synthetic means; it is the natural product derived from suprarenal glands, and the natural product is levoratory. Parke, Davis & Co. stress the fact that their manufacturing process not only yields the levoratory (active) extract, but also that the process is so designed as to keep that extract in its active levoratory condition.